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MEDICARE PAYMENT REFORM: INCREASING CHOICE AND EQUITY

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BEFORE THE

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UNITED STATES SENATE

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MEDICARE PAYMENT REFORM: INCREASING CHOICE AND EQUITY

MONDAY, MAY 19, 1997

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 2:05 p.m., in room SD–562, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Present: Senators Grassley, Hagel, Breaux, Feingold, and Wyden.

OPENING STATEMENT OF CHAIRMAN CHARLES GRASSLEY

The CHAIRMAN. The hearing will come to order. As chairman of the Special Committee on Aging along with my friend Senator Breaux, the ranking minority member, we welcome all of our colleagues who are here as well as the witnesses this afternoon. Today's hearing will focus on the Medicare managed care program, and I want to call this hearing "Medicare Payment Reform: Increasing Choice and Equity." To make it understandable what this hearing is all about, I would like to read a letter I recently received. I believe that the letter captures the essence of the problems better than any of us here in Congress could.

The letter was sent to me April 11 of this year. It was written by Mrs. Cecile Buzzini of Suisun City, CA. I am going to read from that letter, just a short part of it.

"Dear Sir: I read an article in the A.M. paper where you are chairman of the Special Committee on Aging. First of all, I'm 75 years old, and I am planning on moving to Des Moines, IA to be near my daughter. I have an HMO with Kaiser insurance, which isn't located in Des Moines. So I have to change my HMO. But when I checked on HMOs in Des Moines, they don't have any, so I would have to have a supplemental plan, which I had before I joined an HMO. The supplemental plans are very expensive. I still would love to move to your State, but I can't afford your insurance plans. Please reply."[Laughter.]

Well, we here in Washington often find ourselves in this position trying to explain the unexplainable and defend the indefensible. Mrs. Buzzini is exactly right when she says that in Des Moines, and that is Iowa's capital city, we do not have any Medicare risk HMOs. In fact, out of Iowa's 99 counties, there is only one in which seniors have a managed care option.

On the other hand, in many parts of America, seniors may choose among numerous managed care plans. In fact, the plans in

those areas offer extra benefits, competing to attract enrollees. You will see, as you probably already observed the charts here, you will see on the left there an advertisement for Medicare HMOs in a high payment part of our country. This plan through these different columns is comparing all the extra benefits it offers with those offered by regular Medicare. You will see things like prescription drugs, preventive services, vision and hearing care. Is it bad that seniors receive and have access to these benefits? Well, of course not, just as it is not a bad thing that Mrs. Buzzini is satisfied with her plan there in California.

But our seniors are justified in asking: do we not have a single Medicare program in the United States? Is it possible that people who have paid the same payroll tax—during all their working lives—of 2.9 percent have access to widely different choices? Well, it is pretty visible up there in the map of the United States. You will see that it is more than possible that this happens. It is a fact. The widely varying payment rates around the country mean that widely varying choices are available to our seniors. There can be no doubt: Mrs. Buzzini has put her finger on a serious problem in Medicare.

Today's hearing is about solving the problem that is demonstrated by both of those charts. By coming together today, we are getting beyond explaining or defending the status quo. We are trying to fix it. We have a number of witnesses who can help us understand the problem, and they can help us have answers as well.

Now I want to make a point about what this hearing is not about. It is not about playing a blame game. It is not about punishing plans or areas of the country. This problem is caused by our laws, which we here in Congress are responsible for and which we can now come together and try to improve. I know in these kinds of things there is a temptation to focus on winners and losers. But let us not do that. Let us focus instead on making this Medicare program offer more and better choices for seniors in all areas of America.

We have two panels today. The first panel focuses on what is wrong, and the second panel will give us some ideas for solving it. I am ready to hear from other members of the committee. I will start with Senator Breaux.

[The prepared statement of Senator Grassley follows:]

PREPARED STATEMENT OF SENATOR CHARLES GRASSLEY

The hearing will come to order. As chairman of the Senate Special Committee on Aging, I would like to welcome my colleagues and the witnesses to this afternoon's hearing.

Today's hearing will focus on the Medicare managed care program. Its title is "Medicare Payment Reform: Increasing Choice and Equity." To help you understand what this hearing is all about, I'd like to read a letter I recently received in the mail. I believe the letter captures the essence of the problem better than any of us here in Congress could.

The letter was sent to me on April 11 of this year. It was written by Mrs. Cecile J. Buzzini of Suisun City, CA. I'm going to read you an excerpt from her letter.

"Dear Sir, I read an article in the morning newspaper where you are Chairman of the Special Committee on Aging.

First of all I am 75 years of age, and I am planning on moving to Des Moines, IA to be near my daughter. I have an HMO with Kaiser insurance—which isn't located in Des Moines—so I would have to change my HMO. But when I check on HMOs in Des Moines, they do not have any, so I would have to have a supplemental

plan which I had before I joined an HMO. The supplemental plans are very expensive.

I still would love to move to your State, but I can't afford your insurance plans. Please reply."

Well, we here in Washington often find ourselves in this position: trying to explain the unexplainable, and defend the indefensible. Mrs. Buzzini is exactly right when she says that in Des Moines—Iowa's capital city—we do not have any Medicare risk HMOs. In fact, out of Iowa's 99 counties, there's only one in which seniors have the managed care option.

On the other hand, in many parts of America, seniors may choose among numerous managed care plans. In fact, the plans in those areas offer extra benefits, competing to attract enrollees. If you'll look at the easel over here, you'll see an advertisement for a Medicare HMO in a high-payment part of the country. This plan is comparing all the extra benefits it offers with those offered by regular Medicare: prescription drugs, preventive services, vision and hearing care. Is it bad that seniors in that area have access to these benefits? Of course not, just as it's not a bad thing that Mrs. Buzzini is satisfied with her plan in California.

But our seniors are justified in asking: don't we have a *single* Medicare program in the United States? Is it possible that people who have paid the same 2.9 percent payroll tax during their working lives have access to widely different choices? Well, if you'll take a look at this map, you'll see that it's more than possible—it's a fact. The widely varying payment rates around the country mean that widely varying choices are available to our seniors. There can be no doubt: Mrs. Buzzini has put her finger on a serious problem in Medicare.

Today's hearing is about solving that problem. By coming together today, we're getting beyond explaining or defending the status quo: we're trying to fix it. We have a number of witnesses who can help us understand the problem, and help us fix it.

Now, I want to make a point about what this hearing is *not* about: it's not about playing the blame game. It's not about punishing plans or areas of the country. This problem is in our laws, which we here in Congress are responsible for, and which we can now come together to try to improve. I know in these kinds of things there's a temptation to focus on "winners" and "losers." But let's not do that: let's focus instead on making this Medicare program offer more and better choices for our seniors in *all* areas of the country.

We have two panels today. The first panel focuses on what's wrong, and the second panel will give us ideas for solving it.

Senator Breaux, please proceed with your opening statement.

STATEMENT OF SENATOR JOHN BREAUX

Senator BREAUX. Thank you very much, Mr. Chairman. Maybe we could convince that lady to come to Louisiana.

The CHAIRMAN. Well, at least in the southern part of Louisiana, you can do that.

Senator BREAUX. If she lives in New Orleans, she is going to do very well. Mr. Chairman, we want to thank you for calling this hearing and also all of the witnesses that are here today and our guests in the audience.

I think it is becoming increasingly clearer each day and each week we spend in this session of the Congress that while Medicare is a wonderful program that has served people very well for a number of years, it is now a program with a large number of problems. Each day as we learn more and more about these problems and seek ways to try and fix them, it becomes more and more apparent to me that the band-aid type of an approach is just not going to be sufficient if we are going to have a viable working Medicare system to serve us in the 21st century.

What was a wonderful creation in 1965 and has served so well today is fraught with problems because the program has not been able to keep up with the changes in technology and the changes in the rules of how health care services are delivered, particularly with the increasing amount of competition that occurs throughout

the land. So we have to really look to ways to improve the system and provide more choices and more information so seniors can make better decisions about how they want their health care delivered and at the same time do so in a manner that ensures that the program will not go broke with the revenues that we now have going into the Medicare program.

I think we can do that. I will be introducing next month what I would consider to be a major reform package that would allow for the type of health program that we as senators have by making it available to seniors as one of their options. We who participate in the Federal Employees Health Benefits Program certainly have more options and more information and more choices and I think better benefits, and I think that seniors should have that same opportunity to have the same type of benefits that we have. If they think it would be better, they should have that option to enroll in something which is better. We are going to be recommending that approach to the Senate Finance Committee, but on this particular problem here today, there is a tremendous inequity about how HMOs are being reimbursed by Medicare.

What this hearing is about to see if we can come up with some type of a mechanism to try and fix that, inequity and so that people in rural areas have the same opportunities that people have in urban areas. It seems clear from the information I have that we are overpaying some HMOs in some urban areas and underpaying some HMOs in rural areas. How we bring that to a better balance is really the challenge that we have before us.

I am particularly pleased that one of our witnesses today will be professor Kenneth Thorpe of Tulane University. Ken also served as the deputy assistant secretary for Health Policy in the Department of Health and Human Services, and he has provided some very valuable information to me, and I know he will provide the same to the committee this afternoon. Thank you, Mr. Chairman, for having the hearing.

[The prepared statement of Senator Breaux follows:]

PREPARED STATEMENT OF SENATOR JOHN BREAUX

I want to thank Senator Grassley for calling a hearing to look at how rural areas in the United States are impacted by relatively low Medicare HMO payments and what options the Congress has to reform the Medicare payment system.

While Senator Grassley and I hail from States that are impacted differently by current Medicare payment policy, both of us have an interest in fixing Medicare so that payments to HMOs make sense. We also want to consider ways to reform the whole Medicare program—not just payments.

As we consider the proposals we will hear about today, I hope that we remember the saying, "Do no harm." As we talk about raising payments to Medicare HMOs, we need to think about what impact that will have on the Medicare fee-for-service sector. I do not think we necessarily should favor one delivery system over the other. Fee-for-service Medicare, with innovations like case-management, could well make it a good alternative for rural and other areas. In fact, I will be introducing legislation on Medicare case management in the near future.

I also hope, as we consider how to fix the Medicare HMO payment system, that we think "outside of the box"—that we consider new ways to pay Medicare health plans. I will soon be introducing a plan that will restructure Medicare by modeling it on the plan that we and nine million other Federal employees depend upon for our health care: the Federal Employee Health Benefits Plan (FEHBP). The new Medicare program will mean more competition, better benefits, more information, and more choices for beneficiaries.

Mr. Chairman, I am impressed with the witnesses we have before us today. I want to especially welcome Dr. Kenneth Thorpe, a professor at Tulane University

to our hearing. A noted expert on Medicare and health policy in general, Professor Thorpe has also served as Deputy Assistant Secretary for Health Policy in the Department of Health and Human Services. His testimony, which discusses establishing a competitive-bidding mechanism for Medicare, is thoughtfully written and will be of great help as we consider ways to make Medicare work better.

The CHAIRMAN. Senator Wyden.

STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you very much, Mr. Chairman. I want to congratulate you and Senator Breaux for this important hearing. Mr. Chairman and colleagues, I think this is the heart and soul of Medicare reform, and it is clearly time to move now because we have a window of opportunity before the demographic earthquake comes early in the next century.

Mr. Chairman, I would say to a great extent today, Medicare is rewarding waste, penalizing frugality, and engaging in practices that the private sector consigned to the attic years and years ago. As a result of the reimbursement system that we are going to hear about from Hans Running and others today, senior citizens in much of the United States either face no choices for their Medicare, such as the situation in rural Iowa and rural Oregon, or they face choices that defy rational explanation, which is what we will hear about particularly from those in urban areas where some will get prescription drugs and eyeglasses and others will not.

There are a couple of things I hope that we will look at as well as a couple of things that I hope we will avoid. In my view, it is especially important to avoid the approach the Clinton Administration is taking with respect to HMOs. The administration approach essentially says that the efficient health maintenance organization ought to be treated the same as the inefficient health maintenance organization. They cut them all alike. I think that policy is a very serious mistake because it sends all the wrong messages in terms of health care reform.

A number of our colleagues on both sides of the aisle have talked about this issue. I hope that we would look at delinking the reimbursement system for health maintenance organizations from fee-for-service kinds of plans. I think that approach is a good start to bring about equity.

I would like to add that, in our State, we are sort of ambassadors from the future on this topic. We will hear from Mr. Running shortly. In Oregon, we have seen that it is possible to come up with 21st century Medicare that is good for seniors and good for taxpayers, and it is time to lift the penalties against those communities.

So we thank you for this hearing, Mr. Chairman. I particularly thank you for having an Oregon witness, Hans Running, in whose point of view that we are very interested. He has spoken very thoughtfully on these issues. We look forward to working with you and our colleagues in the days ahead.

[The prepared statement of Senator Wyden follows:]

PREPARED STATEMENT OF SENATOR RON WYDEN

Mr. Chairman, I'd like to thank you and our ranking minority member, Mr. Breaux, for holding this hearing on a very important issue.

I'd like to use my time to put forward some thoughts on Medicare that fly in the face of conventional wisdom. Contrary to that conventional wisdom, the bi-partisan 5-year budget agreement recently reached affords us the room and the opportunity to begin real Medicare reform this year.

Clearly, the recent budget agreement stopped far short of the kind of modernization Medicare needs. The new budget has bought American some breathing time—but little else. We cannot slip into complacency at this critical moment. With an impending onslaught of baby boomer retirees, the cost to the American economy of both the Medicare hospital and physician funds will spiral further out of control.

That's if we don't expand competition and choice in Medicare, and if we do not begin to reimburse health maintenance organizations (HMOs) on a more sensible basis. Under S–386, I propose to do exactly these things—to increase consumer choice and promote payment equity. In discussions with colleagues from both sides of the aisle, there remains a great deal of interest in modernizing Medicare, which we can still do this year, and with this budget agreement.

For example, there is nothing in the agreement that bars Congress from redesigning the Medicare reimbursement system, which currently rewards waste and penalizes frugality. The outdated system for paying Medicare HMOs—the Adjusted Average Per Capita Cost (AAPCC)—cheats rural areas out of choices and the extra benefits that HMOs provide elsewhere, as we will hear about in the testimony of Mr. Hans Running from my own State of Oregon.

Medicare choices and Medicare competition—and the higher quality that results—will only come about if Medicare payment is made more equitable. Here we have a lesson to learn from the private sector: reimbursement there forces health plans to compete on the basis of a community's lowest-priced providers. As Medicare operates today, it stands logic on its head and makes payment on the basis of a community's highest-cost Medicare services.

What I have proposed in S–386 is a payment method that reforms Medicare's wasteful reimbursement arrangements: S–386 sets a minimum level for payments in low-paying areas of the country, while insisting that plans in high-paying areas competitively bid to provide Medicare services to our beneficiaries. These two reforms will effectively "even out" Medicare payments to health plans, which will ensure that a beneficiary in rural Oregon has choices and benefits that more resemble a beneficiary's in Los Angeles or Miami.

As I said, there is nothing in the budget agreement that prevents us from increasing the health options for our seniors this year—and nothing to prevent us from reforming Medicare payment policies, which is the "flip-side" of the same coin. There is also nothing in the budget agreement to prevent Medicare from becoming a better educator of seniors regarding their choices—for choice without information is not meaningful choice. Under the 5-year bi-partisan budget agreement, we can make all of these important changes this year.

The encouraging economic factors that helped produce this bi-partisan budget agreement—declining Federal deficits, a growing economy, and relatively low unemployment—also give us a chance to make the real, substantive, and long-term reforms necessary in Medicare. We can prepare the program for the upcoming demographic tsunami of baby boomer retirement by marrying the best ideas from both political parties in Congress.

What we must not do is shrink from this historic opportunity, and then establish a bi-partisan commission to study the problem and offer shelter from political fire. A commission would be a prescription for bi-partisan inertia when we already know what the problems are. Increased choice and equity in payment—which Congress can accomplish today instead of tomorrow—will be the lynchpins of any Medicare reform.

That said, Mr. Chairman, I look forward to the testimony of the panel of this critical issue.

The CHAIRMAN. Thank you. Senator Hagel.

STATEMENT OF SENATOR CHUCK HAGEL

Senator HAGEL. Mr. Chairman, thank you. I too wish to add my thanks to you and Senator Breaux for calling this hearing. I would like to associate myself with the comments made, Mr. Chairman, by you, Senator Wyden, and Senator Breaux. You all have developed a strong base of involved leadership in this issue which we are all grateful for. I might just add one thing. First, I do have a

statement for the record, Mr. Chairman, and I would like to have that included.

We are not in Nebraska unlike many of the States represented on this panel and in the Congress of the United States. Nebraska has 93 counties; of those 93 counties, two have any kind of choice. As a matter of fact, the two lowest reimbursement counties in America are in Nebraska. So we have a rather parochial interest in this, but this is bigger, as we all understand, than just Nebraska, or Iowa, or Louisiana, or Oregon, or Wisconsin. This is about the future of our country and about our young people and our seniors. So I am very pleased to have an opportunity to be here and participate, and I very much look forward to our panels, Mr. Chairman.

The CHAIRMAN. Without any disagreement, your statement will be put in the record.

[The prepared statement of Senator Hagel follows:]

PREPARED STATEMENT OF SENATOR CHUCK HAGEL

Thank you, Mr. Chairman. I appreciate your calling this important hearing on a subject that is very important to my State of Nebraska. I look forward to hearing from our panelists this afternoon as they discuss ways to increase choice and equity in Medicare reimbursement payments.

Under the current system, States like Nebraska are penalized for providing efficient, low cost health care. Medicare reimbursement payments are calculated by formula on a county-by-county basis. All Nebraska counties are low-cost areas—which means our reimbursement rates are low. Strikingly low. The disparity between payments to high-cost areas and payments to low-cost areas unfairly limits the availability of managed care options for Nebraskans.

Under the existing system, high-cost areas get high payments and often attract multiple Medicare managed care plans. Low-cost areas often can't pay enough to attract even a single provider.

Of Nebraska's 93 counties, only two have Medicare managed care options—and both include part of the Omaha metropolitan area. Douglas County has the highest reimbursement rate in the State at $432 per person. Sarpy County is reimbursed at a rate of $375 per person. Those are the only two Nebraska counties with reimbursement rates high enough to support managed-care plans. Yet, their reimbursement rates are well behind the 1997 national average payment of $467—and far, far behind some high-cost urban areas elsewhere in the country that receive as much as $767 per beneficiary.

Clearly, the current system shortchanges Nebraska. In fact, two rural Nebraska counties, Arthur and Banner, currently receive the lowest reimbursement payments in the Nation—only $221 per beneficiary. This isn't fair to Nebraska.

The current system is *doubly* unfair. Nebraskans pay the same Medicare payroll taxes during their working lives as those in other States. But, when they become Medicare beneficiaries, they get much less back because of the flawed reimbursement mechanism. Because of those lower reimbursement rates, Nebraskans have far fewer choices and benefits available to them. Beneficiaries in areas with high payments may be eligible for extra benefits far beyond those covered by traditional Medicare, often for little or no additional premium. But that doesn't help beneficiaries in my home State or other low-cost areas.

We must reform this seriously flawed payment system if we are to offer our Medicare beneficiaries the choices they deserve and if we are to preserve this program for future generations.

We need to find solutions. These may include blending county reimbursement rates with national rates to reduce the current wide variation in rates. These may also include instituting a payment floor to ensure that Medicare beneficiaries in low-payment areas have an option to participate in managed care.

We must offer beneficiaries in Nebraska and elsewhere greater choice in the Medicare program. We must provide for fair payments to all plans that serve Medicare beneficiaries regardless of where they retire. Solving this problem will help revitalize the Medicare system for beneficiaries and providers alike.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Feingold.

STATEMENT OF SENATOR RUSSELL D. FEINGOLD

Senator FEINGOLD. Thank you, Mr. Chairman and the ranking member, for convening the hearing. I want you to know when I heard about this hearing, I changed my schedule right away back home because this is so very important to me and to all of us here. It is both important in the near term as we fashion the details of the bipartisan budget agreement as well as being critical for longer-term reforms that we have to make to Medicare to modernize and strengthen the program.

In the general goodwill that many of us feel about the bipartisan work that can be done to reach a balanced budget agreement, we cannot forget the work that remains to reform our entitlement programs, and this issue is at the very core of those necessary longer-term reforms. Several of you have already referred to this, Senator Wyden in particular. The Chairman and I are scheduled to be at our Budget Committee mark-up later today, and I am heartened by the strong showing of concern that was voiced on this issue during my first meeting ever on the Budget Committee. Of all the issues that could have been brought up about the whole Federal budget, this issue received the most attention. That just highlights how important this is.

I know from a recent visit with you, Mr. Chairman, that addressing this problem is one of your top priorities as it is mine. We both represent States that face many of the same problems under the current system, and I believe that there is a great opportunity to forge a bipartisan solution to this just as we are doing with the balanced budget. In fact, Senator Wyden's comment about how we really have to do it now given what is going on with the budget I think is very apt.

Finally, let me just note that while we are justifiably concerned with ways in which to change the managed care formula to bring about both improved equity and efficiency, I also urge my colleagues to consider the underlying problems on the fee-for-service side that drive the flawed managed care formula. That formula provides disparate reimbursement rates because of the inequities, inefficiencies and abuses that occur in the underlying fee-for-service system.

When we consider reforms to the managed care formula, I hope we will also look at the underlying causes and consider appropriate action. The across-the-board cuts approach to achieving savings in the traditional fee-for-service Medicare system can be as unjust and ineffective as an across-the-board cuts approach would be with respect to the managed care formula. If we expect to have sustainable savings in Medicare, we should target those abuses and inefficiencies, not impose uniform reductions that make no distinctions. So thank you very much to both the Chairman and ranking member for highlighting this issue.

The CHAIRMAN. Well, thank you, Senator Feingold.

Our first panel is already at the table, very distinguished witnesses. Our first witness, Mr. Hans Running, is from Hillsboro, OR. He is a Medicare beneficiary. He has taken time to educate himself on the issues of Medicare managed care payments. He will

be able to put a human face on this sometimes confusing issue, and, of course, to remind us about the inequities in the system and that there are real consequences to our seniors.

Second, we have Dr. Scanlon, who has appeared before this committee and a lot of committees of Congress on a fairly regular basis on this issue. We appreciate your taking so much time to explain the work of the General Accounting Office and particularly the health financing aspects of our Medicare system. You are going to provide background information on the current payment system for Medicare HMOs including the influence of Medicare's fee-for-service payment method, on which managed care payments are based.

Our third witness is a constituent of mine, Steve Brenton, president and CEO of the Association of Iowa Hospitals and Health Systems. He will focus on the obstacles for health providers and plans currently seeking to offer a full range of health care options to rural Medicare beneficiaries. He will discuss whether managed care can play a role in addressing the health care problems of our rural seniors.

Our last witness is Douglas Dillon, a medicare program executive for the Providence Health Systems, based in Portland, OR. He will give the perspective of the health plan which operates a Medicare HMO in an area with a high managed care penetration. He will explain why his plan must charge premiums and offer limited benefits and why the plans cannot serve Medicare beneficiaries in all of its commercial service area. He will also further discuss whether Medicare managed care could become a realistic option for rural seniors, given adequate reimbursement. So we will just go as I introduced them, Mr. Running, Dr. Scanlon, Mr. Brenton, and Mr. Dillon. Go ahead, Mr. Running.

STATEMENT OF HANS RUNNING, MEDICARE BENEFICIARY, HILLSBORO, OR

Mr. RUNNING. Thank you, Mr. Chairman and members of the committee. This is the first time I have ever appeared before such a committee as this so I will do the best I can to articulate what has taken place.

The CHAIRMAN. You will do very well.

Mr. RUNNING. I am 71 years old. For 40 years, I operated my own business. We had 8 to 10 people working for us. We also provided them an opportunity to get health insurance, and then when I turned 66 I sold the business, I went on Medicare. Medicare worked out quite well for us. I had a new experience—lots and lots of paperwork. We were on it for 2 years. We were paying $62.50 for a Blue Cross Medigap. It paid what Medicare generally did not, and we were happy with it, but then HMOs in Oregon began to proliferate and something else changed. All of my doctors who were badmouthing HMOs suddenly joined up, and so we looked into it, and so my wife and I joined an HMO.

Instead of paying $62.50, we began paying $34.50 a month and we were getting many more benefits. We were very happy with this. Now we have been on this Medicare program for 3 years and we are very happy with it. I have family around the country, and I was in California shortly after we joined, and talking to my brother-in-law, and he said he was on a Medicare program or an HMO,

Secure Horizons. He said he is not paying anything. Not paying anything? Gee, that sounded pretty good. I thought he might be mixed up on things. He was a retired executive from Sunkist. I thought maybe Sunkist was paying part of it. No. He was getting it for nothing.

So when I returned home, I called Secure Horizons in Oregon. Nothing sounded a little bit better than $34.50. I asked if I could join? Oh, yes, they would be happy to have me join at $44 a month, same company, a plan that had less care in Oregon than it did in southern California. Well, I could not believe this. So I called our Oregonian and said there is something wrong here. Why in the world do we have to pay so much more in Oregon than they pay in California? The Oregonian did a story on this, and they quoted me, and suddenly I became something of an expert on Medicare and HMOs. [Laughter.]

Some of the phone calls that I got were almost unbelievable. One person called and said I have belonged to AARP for 10 years, and I did not know about this. I am going to send this to them and insist that they print it and get this information out. Another man said let us form an organization so that we can get true and accurate information with regard to HMOs. Several of them said that they were going to write our congressional delegation. Now, the HMOs are continually changing. They are changing in a way that is almost unbelievable. Example: my own HMO that I have been with was charging me $34.50 a month. In 14 months, it went from $34.50 a month to $9.50 a month to zero a month, and now it is back to $9.50 a month. These figures are correct. We have a hard time understanding why that is.

When I looked into it a little further, then I discovered something that shocked me even more, and that is that if I lived in California, the government would pay my HMO about $650 per month. Living in Oregon, they pay my HMO $300 a month, and I have a brother in South Dakota that cannot get an HMO, and if they did, the HMO would only be paid $200 a month. Now, if this makes sense to you, it does not to me. My wife and I now draw $20,000. This year we will draw $20,516 in Social Security payments. We are very healthy. Our health costs, total health costs, run 20 percent, almost 20 percent of my total Social Security payments.

Now if we paid in all these years on Social Security, I am drawing my healthy Social Security to which I am very happy, and I know I can count on it, but I have also paid money into the Medicare system. Yet, the two are similar in the way they collect taxes, but they are not the same when it comes to delving it out. So if they are going to have this wide range of payments for the HMO, if that is a good idea, then they ought to go to the same thing in Social Security and make their payments regionalized so that the people who live in a high area will get more Social Security, and those of us who live in more frugal areas will pay less. Thank you, Mr. Chairman.

[The prepared statement of Mr. Running follows:]

May 14, 1996

Statement to the Senate Special Committee on Aging:
Scheduled at 2pm Monday May 19,1997 by Hans Running

My name is Hans Running. I live in Hillsboro, Oregon. I am 71 years old, and for nearly 40 years I owned and operated a small photography business--very small--annual sales were around half a million dollars. I employed six to 10 people. During this time, I made health care available to employees, paying half of their monthly premiums. I sold the business to a large national firm that had a fine health care for employees--and stayed on for three years during the transition of management.

When I turned 66, I retired and entered the Medicare program. I knew Medicare paid for a good portion of medical costs, but I had little idea of details. My wife was not yet eligible for Medicare, but was able to continue coverage under COBRA. I was on Medicare for several months with a Medigap supplement that paid most of the charges not covered by Medicare. We were amazed at the amount of paperwork that accumulated during that time even though I had no serious health problems. We weren't really interested in joining a Health Maintenance Organization (HMO) because the doctors we had used for more than three decades were not affiliated with any of the HMOs.

Then late in 1993 ALL of our doctors signed on to the HMO we were considering--and when we heard that by paying $34.50 per month to the HMO instead of $62.50 per month for a Medigap policy, a great deal of paper work would be eliminated and we could get better care and more coverage we joined. Generally speaking we have been happy with our choice.

What I discovered after I joined my HMO--and this is little understood by many subscribers--is that when I signed on, I was NO LONGER ON MEDICARE. True, Medicare pays for most of it. I can pull out of my HMO and return to Medicare. And if I don't believe my HMO is treating me right, I can appeal to Medicare. But my Medicare card will not be honored.

It has been my experience that when Medicare HMOs are discussed, few care how they are funded. Those who belong usually know little more than the amount of their monthly premium, what their copayment is when they go to the doctor's office, what they get "off" when buying drugs. If their former employer provides some medical coverage they have no idea of how much the employer is paying. Their only concern seems to be how much they must pay themselves.

Most of those retirees I've talked to not now belonging to an HMO say they will never join one. They have been poisoned by the bad-mouthing of HMOs mostly by speciality medical doctors who find that their number of referrals is reduced when HMOs look over their shoulders. They speak disparagingly of them--until they learn that if they are to survive in their speciality they must join up. Other retirees are reluctant because they believe they will no longer have a choice of their personal physician or a specialist. "I want to chose my doctor, " they cry. This is true to

some degree though all the HMOs in our part of Oregon have an extensive roster of doctors and specialists.

It's almost impossible to compare HMO charges and benefits with other HMOs throughout the country. Since January 1,1995--a period of 14 months, my own HMO premium gyrated from monthly fees of $34.50 to $9.50 to zero to $19.50 where it is today. In just 14 months!

I have family scattered around the country and during family meetings, conversation for those of us over the magic age of 65 inevitably turns to health care. When my brother-in-law from Orange County in California said they were enrolled in a HMO and it cost him nothing, I thought he must be smoking something. Nothing? How could that be? And he added that they got their prescriptions for only $5 each. Gordon Henderson was the retired sales manager for Sunkist and I thought, perhaps his former employer was paying the monthly premium. Gordon's HMO was a national firm, Secure Horizons, and they had a large presence in the Portland, Oregon area where I live.

When I returned home, I called Secure Horizons--thinking that maybe we should enroll in their plan. They would be happy to have us, I was told, only it would cost us $44 each per month. Why, I asked, is it $44 in Oregon and nothing in the affluent area of Laguna Niguel, California. "Because there are so many people there," I was told.

I knew that my government was subsidizing my health coverage and when I tried to find out just how much, I couldn't find anyone who knew. I called my HMO, was told that each month they get a big check from the government. When I asked how much my HMO got for covering Hans Running, they said they couldn't tell me. They suggested that I call Social Security. I called Social Security, who said I should call Medicare and Medicare said I should call Blue Cross or maybe Aetna insurance, the private agencies administering Medicare in Oregon.

My persistence finally paid off. What I discovered was that the government was paying my HMO about $300 monthly in Oregon and if I lived in southern California they would pay $650. This shocked me. I called our large regional newspaper, *The Oregonian*. I suggested they do a story on what I believed was gross unfairness in coverage.

Two weeks passed and the newspaper called me. They told me that they found it hard to believe my numbers. So as they began to check the facts they, too, were surprised. As a result, *The Oregonian* did an extensive story reflecting these facts, featuring a picture of my wife and me. From that news story, calls and letters came to me from angry people--angry because they had no idea of how Medicare and HMOs work..

One man called to tell me he had belonged to AARP for 10 years, read everything they published about Medicare and HMOs but had never been told of this. He said he would send the story to AARP and demand they tell the truth to their members.

George Dobbins of Lake Oswego said a group should be formed so that this information could be shared. He said there was just no place we can turn and get straight, understandable answers. Several said they were sending the story to our Congressional delegation. They didn't believe that our lawmakers could possibly approve of such inequity.

Even several doctors I talked to--both in and out of HMOs found these numbers difficult to believe.

Meanwhile, my brother-in-law in California became very ill. During the last 30 days of his life--18 days in and out of intensive care he was seen by many specialists. The family paid not one dime for this extraordinary care which, they estimate, cost more than $100,000.

Why should the government handsomely subsidize such care in southern California at $650 monthly? I have a brother who lives in South Dakota where there is no HMO available. If an HMO existed there, the government would pay the HMO little more than $200 a month, not the $650 it would pay if he were lucky (or unlucky) enough to live in California..

During my productive years, I paid Social Security and we will collect $20,516 this year including Medicare premiums. (With all the government help, nearly 20% of our Social Security is gobbled up by our health care--and we are quite a healthy couple.) The amount I collect is based on my lifetime earnings. It would be exactly the same if I lived in Spearfish, South Dakota, Orange County, California or New York City. Medicare payroll taxes are the collected in the same way --uniform throughout the country--based on earnings. Yet, when it comes to returning these funds to the elderly, they use an entirely different formula--that invokes an entirely different public policy. Why?

Proponents of the present plan say it is proper because medical care costs more in some parts of the country than others. If that makes sense, then perhaps Social Security payments should be adjusted throughout the country to reflect the cost of living. Perhaps Congress should float that plan before elderly voters.

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The CHAIRMAN. Thank you, Mr. Running. Dr. Scanlon.

STATEMENT OF WILLIAM SCANLON, PH.D., DIRECTOR, HEALTH FINANCING AND SYSTEMS, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC

Mr. SCANLON. Thank you, Mr. Chairman and members of the committee. I am very pleased to be here today as you discuss greater choice and equity issues in Medicare's risk contract HMO program. Today my remarks are going to focus on how HCFA HMOs rate setting system coupled with other factors contributes to the very unevenness in the program that Mr. Running just described. A more detailed discussion is contained in my written statement.

Risk contract HMOs, as you know, are Medicare's principal managed care option. They have been seen as a means of better controlling program costs and advantageous to beneficiaries because of their potential to offer additional benefits at a lower out-of-pocket costs than the traditional fee-for-service Medicare. However, unevenness in the nationwide availability of Medicare risk HMOs is a significant problem. The majority are concentrated in urban areas while rural areas have few or none. In addition, the premiums they charge and the benefits they offer differ across the country, as Mr. Running has so ably indicated.

If you are a member of Medicare's PacifiCare plan and live in southern California, as he has found out, you do not have to pay an HMO premium, and you are likely to receive an unlimited prescription drug benefit. However, if you are a PacifiCare member and live in Portland, you pay a $37 monthly premium and get no prescription drug benefit. One reason, but not the only reason, for the diversity in plan availability and benefits is the Medicare HMO payment rates are set individually for every county based on the county's Medicare spending in the fee-for-service sector.

As a result, the base HMO payment rate, widely known as the AAPCC, or the Adjusted Average Per Capita Cost, varies significantly among counties. For example, there is more than $500 difference in AAPCC rates between Arthur County, NE and Richmond County containing Staten Island in New York. Significant disparities occur even within a single urban area. Consider, for example, the Philadelphia metropolitan area. The differences in AAPCC's there result in an HMO receiving $188 more for serving one county's residents than for serving a resident of a neighboring county, even if the two beneficiaries see the same physicians and use the same health care facilities.

Basing HMO rates on fee-for-service spending has created this variation. As you know, medical prices are higher in some areas than others, and the amount of medical services consumed depends in part upon local medical practices and access to care, which also differ across the country. Variation in prices of services which while very important do not explain the majority of the differences in HMO rates. Adjusting for the price differences in the two counties I mentioned, Arthur County, NE, and Richmond County, NY, reduces the more than $500 differential by 39 percent, but a gap of $332 nevertheless remains.

In addition to the AAPCC rates, other factors play a key role in the risk contract program's unevenness. A county's size is impor-

tant to plans' availability. HMO officials have told us that they seek to enroll at least 10,000 Medicare beneficiaries within a few years of startup to spread both their risks and their administrative costs. Medicare also requires HMOs to have minimum numbers of commercial enrollees to participate in the program.

Both factors result in many rural counties having no Medicare HMOs. The Physician Payment Review Commission has indicated that 85 percent of rural residents live in a county without an HMO option available to them. Market conditions, especially the degree of competition, from other HMOs, is also an important factor in whether an HMO charges a premium and what benefits it offers. It produces some of the same type of variation over time in premiums as Mr. Running has noted. Plans may offer lower premiums and benefits in part because Medicare does not allow HMOs to earn a greater return on their Medicare beneficiaries than the plan can earn on its commercial enrollees.

However, many plans go well beyond what Medicare requires in order to attract a bigger market share. For example, Health Options operating in the competitive south Florida market waives the $94 monthly premium it could charge for its benefit package to attract more beneficiaries. Medicare's method for setting HMO rates has also compromised the risk contract program's potential to produce Medicare savings. It is widely acknowledged that HMOs attract healthier than average beneficiaries. Basing the AAPCC on fee-for-service spending then means that the less healthy, more expensive beneficiaries remaining in fee-for-service become the norm for the AAPCC rate.

It also is recognized that HCFA's methods for risk adjusting the AAPCC to reflect HMO enrollees' health status are not adequate. So that both the AAPCC rate and the actual rate paid after adjustment are often too high. Because of these flaws, we have found in recent work overpayments amounting to $1 billion were made in 1995 to HMOs in California which contain about 40 percent of Medicare's HMO enrollees.

In conclusion, the AAPCC rate system together with other factors have created a dramatically uneven program. Addressing the rate setting flaws would be an essential first step if the risk contract program is to realize the potential of program savings, enhanced benefits and beneficiary equity. Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or members of the committee may have. Thank you.

[The prepared statement of Mr. Scanlon follows:]

United States General Accounting Office

GAO

Testimony

Before the Special Committee on Aging, U.S. Senate

For Release on Delivery
Expected at 2 p.m.
Monday, May 19, 1997

MEDICARE MANAGED CARE

HMO Rates, Other Factors Create Uneven Availability of Plans and Benefits

Statement of William J. Scanlon, Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

GAO/T-HEHS-97-133

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you discuss aspects of Medicare managed care, including greater choice and equity across the program. In fiscal year 1997, federal expenditures for Medicare benefits are expected to reach nearly $209 billion. The Congressional Budget Office estimates that costs will rise an average of 8.4 percent a year during fiscal years 1998 through 2002. As the Congress seeks ways to slow this growth rate, several proposals have been made that would encourage beneficiaries to join risk contract health maintenance organizations (HMO). Risk contract HMOs have the potential to be advantageous for two reasons. First, the payment of a capitated rate for all services needed by each enrolled beneficiary gives these plans a financial incentive to hold down costs.[1] In addition, risk contract HMOs often provide Medicare enrollees additional benefits at lower out-of-pocket costs than Medicare fee-for-service coverage.

As you know, Medicare risk HMO plans are not available nationwide, and differences in premiums charged and benefits offered across the country produce inequities for Medicare program beneficiaries. In addition, as we recently reported,[2] the risk contract program has not realized the savings that were anticipated from enrolling beneficiaries in capitated managed care plans. Concerned about program inequities and the lack of savings from risk HMOs, you asked us to discuss the mechanics of the current risk HMO payment system and its shortcomings–including why the system produces differences in HMO availability and benefit packages for beneficiaries and fails to produce expected savings for taxpayers. I will focus on (1) the link between counties' capitation rates and Medicare's spending on fee-for-service care; (2) factors affecting the availability of plans in a given area, the level of premiums charged, and the benefit packages offered; and (3) modifications to Medicare's current payment methodology that could reduce HMO overpayments.

My remarks today are based primarily on analyses done for our recently issued work on HMO rate setting and the enrollment of HMOs in Medicare's risk contract program. (A list of related GAO products appears at the end of this statement.)

In summary, Medicare's risk HMO payment system, which is built largely on fee-for-service costs, accounts for some, but not all, of the unevenness in Medicare's risk contract program. Differences in local medical prices and service utilization explain

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[1]Other Medicare managed care plans include cost contract HMOs and health care prepayment plans, which together enroll fewer than 2 percent of the total Medicare population. Because Medicare pays these plans using methods other than capitation rates, they are not the subject of this statement.

[2]Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

much of the variation in HMO capitation rates across counties. In turn, the variation in capitation rates explains some of the differences across locations in availability of risk contract HMOs, level of HMO premiums charged, and richness of benefits offered. However, other factors also play an important role.

Reducing the uneveness in and realizing the savings potential of, the risk contract program involves reforming its payment system. As a start to that process, we have proposed correcting a flaw in Medicare's rate-setting method that currently contributes to excess payments to HMOs. Our proposed modification could also help smooth the unevenness in counties' HMO capitation rates.

BACKGROUND

Medicare provides health care insurance for nearly all elderly Americans (those aged 65 and older) and certain of the nation's disabled. It is administered by the Health Care Financing Administration (HCFA), an agency of the Department of Health and Human Services (HHS). Although most Medicare services are provided through the fee-for-service sector, in recent years, greater numbers of Medicare beneficiaries have enrolled in HMOs to receive covered services.

Medicare risk HMOs must cover all Medicare part A and part B services. However, many risk HMOs also cover part A and part B copayments and deductibles and additional services that are not covered under traditional Medicare--such as a portion of the costs of outpatient prescription drugs, routine physical exams, hearing aids, and eyeglasses. HMOs are allowed, subject to certain Medicare restrictions, to charge beneficiaries a monthly premium for cost-sharing and services not otherwise covered by Medicare. However, nearly two thirds of HMOs do not charge beneficiaries a monthly premium.[3]

Congressional interest in risk-bearing HMOs dates from the Social Security Act Amendments of 1972 (P.L. 92-603). Under the 1972 law, if an HMO's costs were less than its capitation payments, it was required to share these profits with Medicare. In addition, an HMO's profits were capped at 10 percent of its total payment from the government. However, if an HMO's costs exceeded its payments from Medicare, the HMO had to absorb the loss or carry it over to offset future profits from its Medicare business. Few HMOs contracted with Medicare under this arrangement.

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[3]All beneficiaries enrolled in HMOs must, however, continue to pay their part B premium to Medicare.

In 1982, the Congress modified Medicare's rate-setting method, creating the risk contract program that exists today.[4] One significant change was that the Congress eliminated the 1972 law's requirement that an HMO's Medicare profits be completely shared with Medicare. Instead, HMOs are permitted to retain all profits up to the levels they earn on their non-Medicare business.

As of May 1, 1997, 280 HMOs[5] participated in Medicare's risk contract program. Recent growth in enrollment of plans in the risk contract program has been rapid but uneven across the country. When we reported on 1994 enrollment trends, for example, 15 states had experienced double-digit growth increases, whereas the other states had experienced little or no growth.[6] At the end of 1996, California, Florida, New York, Texas, and Washington had the largest number of risk contract HMOs, whereas 37 states had five or fewer of these plans. Medicare's enrollment of beneficiaries in risk HMOs is currently growing by about 85,000 beneficiaries per month. As of May 1, 1997, 4.6 million, or nearly 12 percent, of the approximately 39 million Medicare beneficiaries were enrolled in risk HMOs.

DIVERSITY IN CAPITATION RATES ACROSS COUNTIES IS DRIVEN BY VARIATION IN LOCAL MEDICARE FEE-FOR-SERVICE SPENDING

Medicare law ties HMO capitation rates to spending in the traditional fee-for-service program. Every year, HCFA calculates per-beneficiary spending in each county's fee-for-service sector and, using projections of spending growth, determines capitation rates for each county in the following year. Fee-for-service costs vary widely among counties because of differences in medical prices paid and in beneficiaries' use of services. Therefore, HMO capitation rates, directly based on fee-for-service spending, can vary considerably from one county to another.

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[4]The legislation creating this program is contained in section 114 of the Tax Equity and Fiscal Responsibility Act (P.L. 97-248).

[5]Competitive medical plans, which also enter into risk contracts with Medicare to serve beneficiaries, are included in this figure.

[6]Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

HCFA's Process for Determining an HMO's Payment Rate Is Tied Directly to Medicare's Fee-for-Service Spending

Medicare law stipulates that the capitation rate be set at 95 percent of the costs Medicare would have incurred for HMO enrollees if they had remained in fee-for-service.[7] Under Medicare's current rate-setting method, HCFA each year uses the Medicare costs incurred by a county's fee-for-service beneficiaries to develop an estimate of each county's average fee-for-service spending in the following year.[8] The result, multiplied by 0.95, produces a county rate known as the adjusted average per capita cost (AAPCC).[9] In projecting spending growth, HCFA's calculations take into account national trends in inflation and utilization patterns as well as changes in Medicare program provisions.

To arrive at the capitation rate paid for each HMO enrollee, HCFA applies a risk-adjustment factor to the AAPCC that is intended to align the rate with how much an enrollee's expected costs differ from the average beneficiary's cost. Our work has shown that, even after HCFA's risk adjustments, the capitation rate is only weakly related to a beneficiary's expected fee-for-service costs.

Variation in Fee-for-Service Spending Produces Diversity in Counties' AAPCC Rates

In 1997, the average AAPCC was $395 per month.[10] However, AAPCC rates vary dramatically from place to place–from a low of $221 in Arthur County, Nebraska, to $767 in Richmond County (Staten Island), New York (see fig. 1). Even among counties in the same geographic area, substantial rate variation can exist. For example, in the Philadelphia metropolitan area, Philadelphia County's AAPCC is $704, but in neighboring Montgomery County, Pennsylvania, the AAPCC is $516. Because capitation rates are based on a beneficiary's county of residence, a Philadelphia-area HMO would receive $188 more for serving a Philadelphia county resident than it would for serving a Montgomery County resident with identical demographic characteristics. The payment differential remains, even if the two beneficiaries see the same physician and use the same medical facilities.

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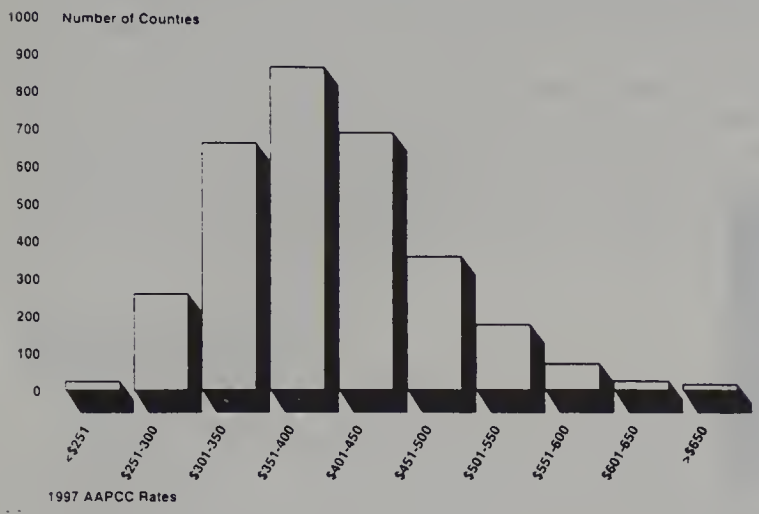
[7]Section 1876(a)(4) of the Social Security Act (42 U.S.C 1395mm(a)(4) (1994)).

[8]Through this process, HCFA determines county-specific Medicare expenditures for part A and part B for the elderly and the disabled.

[9]HCFA calculates separate cost figures for Medicare part A and part B services for the aged, the disabled, and people with end-stage renal disease.

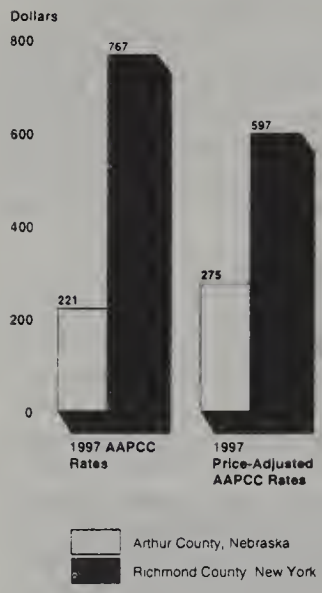
[10]The average county rate weighted by the number of beneficiaries living in each county is $468. AAPCC rates discussed in this statement exclude rates for the U.S. territories.

Figure 1: Distribution of Counties by 1997 AAPCC Rates



The wide variation in HMO payment rates is a consequence of the variation in local Medicare fee-for-service expenditures which, in turn, is caused by local differences in both the prices of medical services and the quantities of medical services consumed. To illustrate that price differences alone cannot fully explain the variation in AAPCC rates, figure 2 shows an estimate of the AAPCC rate that would exist in Arthur County, Nebraska, and Richmond County, New York, if the cost of medical services in both counties were equal to the national average. Although an adjustment for differences in medical prices reduces the original $546 AAPCC rate differential by 39 percent, a gap of $332 nevertheless remains.

Figure 2: 1997 AAPCC Rates and AAPCC Rates Adjusted for Local Medical Costs in Arthur County, Nebraska, and Richmond County, New York



Differences in the quantity of medical services beneficiaries receive account for the variation in AAPCC rates not attributable to differences in local prices. HMO capitation rates are higher in counties where beneficiaries use more services (or a more expensive mix of services) compared with counties where beneficiaries use fewer services. An example of variation in service utilization is Medicare beneficiaries' use of short-stay hospitals. In 1994, Utah beneficiaries averaged 1,270 days of hospital care per 1,000 beneficiaries, whereas New York beneficiaries averaged 3,738 days of hospital care per 1,000 beneficiaries.

Some of the variation in the use of medical services may reflect inappropriate levels of care. For example, low utilization could be caused by access-to-care barriers, such as inadequate transportation or a lack of providers in rural areas. Similarly, some high utilization could represent excessive use of medical services. Nonetheless, current fee-for-service medical utilization rates--whether appropriate or not--are an important factor in determining HMO capitation payment rates.

Instability of capitation rates from year to year may also discourage some HMOs from locating in areas with few beneficiaries. Between 1996 and 1997, the average AAPCC rate increased by about $23, or just over 6 percent. However, some counties' rates increased much more than the average while others decreased substantially.[13] In counties with a small number of beneficiaries, a relatively few expensive medical cases in 1 year can drive up Medicare fee-for-service expenditures (and therefore HMO rates), while an especially "healthy" year can reduce expenditures. HMO officials have stated that such rate instability impairs long-term planning efforts–for example, by complicating decisions about investing in new clinics and expanding physician networks. By using a 5-year average of fee-for-service data to determine a county's AAPCC rate, HCFA dampens–but does not eliminate–the effect of fluctuating fee-for-service costs on HMO payment rates.

HMO Profit Restrictions, Competition Also Influence Premium Rates and Benefit Package

Beneficiaries' out-of-pocket costs and the benefits they receive depend on where they live as well as on which HMO they join. For example, beneficiaries living in southern California who enroll in PacifiCare pay no monthly premium and may receive an unlimited annual prescription drug benefit. In contrast, beneficiaries who enroll in PacifiCare in Portland, Oregon, pay a $37 monthly premium and receive no prescription drug benefit.

Geographic differences in capitation rates (PacifiCare of southern California receives an average monthly capitation rate of $497, while PacifiCare of Oregon receives $338) explain part of the premium and benefit variation, but not all. Restrictions on HMO profits and the amount of local competition among HMOs also influence the out-of-pocket costs beneficiaries must pay and the benefits they receive.

Medicare's HMO Profit Restrictions

Medicare's restrictions on HMOs' profit-making partly explain the link between capitation payments to HMOs and their benefit packages. Medicare does not permit HMOs to earn profits on their risk contracts that are higher than on their commercial business. If HCFA estimates that the capitation payments would result in an HMO earning excess profits, the plan must reduce premiums (or other beneficiary out-of-pocket expenses), offer additional benefits, or return money to the program. Virtually all HMOs in this situation decide to reduce premiums or offer additional benefits.

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[13]For example, the AAPCC rate in Loving County, Texas, fell 40 percent (from $881 to $527), while the rate in Culberson County, Texas, rose 37 percent ($355 to $487).

HCFA attempts to enforce Medicare's restrictions on HMOs' profits through what is known as the "adjusted community rate" (ACR) process. Before each contract year, every HMO submits to HCFA a proposal–called the ACR proposal–that describes the HMO's planned package of benefits (which may go beyond those covered by fee-for-service Medicare) and monthly premiums and other charges to beneficiaries. The ACR also includes an estimate of the amount the HMO would have charged commercial enrollees for a similar benefits package. Although this estimate may initially be based on HMOs' actual charges, numerous adjustments must be made to account for the generally higher utilization of services by Medicare beneficiaries compared with commercial enrollees and any differences in benefit coverage between the two groups. HCFA reviews the ACR proposal to determine whether the plan must offer additional benefits to enrollees and the maximum premium the plan will be permitted to charge. The net result is that the more an HMO will profit from its Medicare business, the more additional benefits Medicare enrollees receive.

Competition for Market Share

The amount of local competition among HMOs for market share can also influence the level of HMO premiums and benefits. Through the ACR process, HCFA approves the maximum premium (and other beneficiary out-of-pocket costs) an HMO may charge for its proposed benefit package. HMOs may, however, charge a premium lower than the one approved by HCFA or offer benefits beyond those included in the plan's ACR proposal. Many HMOs seeking greater market share take advantage of this option. For example, Health Options, Inc., operating in the competitive south Florida market, is permitted to charge a monthly premium of $94 for the package of benefits contained in its ACR proposal. However, Health Options has waived this premium–beneficiaries pay no monthly fee. PacifiCare, in the competitive Los Angeles market, is allowed to charge a $12 monthly premium for its package of benefits, which includes a prescription drug benefit with a $2,500 annual limit. As with Health Options, however, market forces induced PacifiCare to go beyond the ACR requirements. PacifiCare enrollees in the Los Angeles area pay no monthly premium, and some receive an unlimited annual drug benefit.

CORRECTING RATE-SETTING FLAWS ADDRESSES HMO OVERPAYMENT PROBLEM, MAY REDUCE RISK CONTRACT PROGRAM UNEVENNESS

The variation in the risk contract program that produces inequities across the country in Medicare beneficiaries' costs and benefits is a manifestation of rate-setting flaws that produce HMO overpayments. As mentioned earlier, favorable selection–the tendency of HMOs to attract healthier than average beneficiaries–produces AAPCC rates that are higher than warranted in some counties. Favorable selection can result in overpayments to HMOs.

HMO enrollment patterns may also contribute to the county variation in the use of fee-for-service medical services. It is widely acknowledged that HMO enrollees tend to be healthier than beneficiaries who remain in fee-for-service--a phenomenon known as favorable selection. As we recently reported, the growing enrollment of a county's generally healthier Medicare beneficiaries in risk HMOs drives up the medical service use rates for the generally sicker beneficiaries remaining in fee-for-service.[11]

CAPITATION RATES ALONE DO NOT DETERMINE HMO AVAILABILITY, PREMIUMS CHARGED, OR BENEFITS OFFERED

There is a significant correlation between Medicare's capitation rates and the availability of Medicare HMOs in different areas, the premiums these plans charge, and the benefits they offer. However, a number of exceptions suggests that other factors, such as the concentration of Medicare beneficiaries and the availability of HMOs to the non-Medicare population, play an important role.

Population Size and Rate Volatility Also Likely Influence Plan Participation in a Given Area

Medicare HMOs are not available everywhere. Nationally, 63 percent of beneficiaries have at least one plan available to them; 25 percent have five or more plans available. Many HMOs are concentrated in urban areas, while rural areas have few or no HMOs. Because capitation rates are typically higher in urban areas than in rural areas, Medicare payment rates to HMOs are often considered to be an important influence on Medicare HMO availability. However, other factors--such as county size and the stability of the capitation rate from year to year--also play a key role.

Many counties with low AAPCCs are sparsely populated. Such counties simply may not have enough potential enrollees to make an HMO financially viable. As we recently reported, HMO officials have stated that plans need to enroll at least 10,000 Medicare beneficiaries within a few years to spread both financial risk and their fixed costs.[12] In addition, many rural counties are not served by commercial HMOs. This precludes the formation of Medicare HMOs, because Medicare requires that HMOs serving rural areas have at least 1,500 commercial members (5,000 for nonrural HMOs) and that at least 50 percent of their enrollees be commercial members.

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[11]GAO/HEHS-97-16, Apr. 25, 1997.

[12]Medicare HMO Enrollment: Area Differences Affected by Factors Other Than Payment Rates (GAO/HEHS-97-37, May 2, 1997).

First, as discussed earlier, estimating a county's average cost of serving Medicare beneficiaries under fee-for-service is central to the current method for setting HMO rates. The problem is that HCFA's method excludes HMO enrollees' costs from estimates of the per-beneficiary average cost and bases the AAPCC only on the cost of the county's fee-for-service beneficiaries. Thus, the rates generated reflect the costs of only a portion of the county's Medicare beneficiaries–a portion which, according to the preponderance of research on this subject, is generally more costly than the portion of beneficiaries enrolled in HMOs. In this way, the current method generates rates that result in overpayments to HMOs in counties where the Medicare HMO population is, on average, healthier than the Medicare fee-for-service population.

A difficulty in correcting the problem is that HCFA cannot directly observe the costs HMO enrollees would have incurred if they had remained in the fee-for-service sector. We have proposed a modification that addresses this problem. We developed a way to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA, thus generating an AAPCC that represents the costs of all Medicare beneficiaries.

On the basis of our work examining the AAPCC rates of California's 58 counties,[14] we found that in 1995 our method would have reduced excess payments to HMOs by $276 million, or about 25 percent of total excess payments. Thus, if HCFA adopted our modification, Medicare could save hundreds of millions of dollars in HMO overpayments.

HCFA recognizes the effect of favorable selection on AAPCC rates. The administration's current budget proposal calls for an across-the-board reduction in Medicare's HMO payments that would lower the payments from 95 percent to 90 percent of estimated fee-for-service costs. Our modification to calculating AAPCC rates takes a more targeted approach. Under our method, HMOs in counties with higher excess payments would receive greater payment reductions than HMOs in counties with lower excess payments. The modification could be applied to HCFA's current payment method or other methods that rely on fee-for-service costs to set or update HMO rates. (See the appendix for a more detailed discussion of our work.)

Second, favorable selection results in overpayments to HMOs because of HCFA's method of risk adjustment. Medicare's risk adjusters explain only about 3 percent of the variation in individual-level health care costs and are thus not adequate to account for the cost differences among beneficiaries. The difficulty is that the risk adjusters are not precise enough to distinguish between two beneficiaries who may be demographically

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[14]We selected California because, at the time of our review, it covered 36 percent of all Medicare enrollees and includes counties that in 1995 had the nation's highest HMO penetration rates. Our estimates pertain to a large portion of the risk contract program; we did not develop a national estimate.

identical but who may have significant health differences. For example, of two beneficiaries alike in age, sex, and the other demographic traits considered by HCFA's risk adjusters, one may experience occasional minor ailments, while the other may suffer from a serious chronic condition. Because such dramatic differences in health status are not captured in risk adjustment, some HMOs receive payments that are higher than justified by the expected costs of their enrollees.

HCFA announced in January 1997 that it was about to launch a demonstration project on two risk-adjustment systems that seek to differentiate more and less costly patients on the basis of diagnostic information from inpatient, outpatient, and physician encounters. HCFA has not announced a schedule for implementing a better risk adjuster programwide.

CONCLUSIONS

The AAPCC system, with its linkage to fee-for-service expenditures, is an imperfect mechanism for setting capitation rates. It incorporates some local factors–such as service utilization differences–that may be inappropriate without adequate adjustments. As a result, the system assigns some counties AAPCC rates that are too low and other counties rates that are too high. Coupled with such factors as market competition and Medicare's complex ACR process, Medicare's payment system results in dramatic contrasts in HMO plan availability, out-of-pocket beneficiary costs, and benefit packages. Addressing the flaws in setting capitation rates is essential if the risk contract program is to realize the potential of program savings, enhanced benefits, and beneficiary equity.

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Mr. Chairman, this concludes my prepared statement. I will be pleased to answer any questions.

For more information on this testimony, please call Jonathan Ratner, Associate Director, on (202) 512-7107 or James C. Cosgrove, Assistant Director, on (202) 512-7029. Other contributors to this product include Richard M. Lipinski and Hannah F. Fein.

INCLUDING HMO ENROLLEES' COSTS IN COUNTY AVERAGE CALCULATION IMPROVES ACCURACY OF AAPCC

Modifying the method for calculating adjusted average per capita cost (AAPCC) rates would help reduce Medicare's excess health maintenance organization (HMO) payments in counties with healthier-than-average Medicare HMO enrollees. In setting AAPCC rates, the Health Care Financing Administration (HCFA) currently estimates the average Medicare costs of a county's beneficiaries using the costs of only those beneficiaries in Medicare's fee-for-service sector. This method would be appropriate if the average health cost of fee-for-service beneficiaries were the same as that of demographically comparable HMO enrollees. However, in counties where there are cost differences between Medicare's fee-for-service and HMO enrollee populations, this method can either overstate the average costs of Medicare beneficiaries and lead to overpayment or understate average costs and lead to underpayment. Correcting this problem is difficult because it is impossible to observe the costs HMO enrollees would have incurred if they had remained in the fee-for-service sector. Therefore, we developed a method to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA. Our method consists of two main steps:

- First, we compute the average cost of demographically similar new HMO enrollees during the year before they enrolled--that is, while they were still in fee-for-service Medicare. These fee-for-service costs are available through HCFA's claims data.

- Next, we adjust this amount to reflect the expectation that a new enrollee's use of health services will, over time, rise.[15]

Having completed these steps, we combine the result with an estimate of the average cost of fee-for-service beneficiaries. This new average produces an AAPCC rate that reflects the costs of all Medicare beneficiaries.

Selected 1995 AAPCC Rates Produced Substantial Excess Payments

To illustrate the effect of our approach, we analyzed data for counties with different shares of beneficiaries enrolled in HMOs. We chose counties within a single state to

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[15]Our analysis adjusts for (1) the tendency for enrollees' costs to become more like--or "regress" toward--the fee-for-service cost mean after joining an HMO and (2) the costs incurred by HMO enrollees who die while enrolled, because last-year-of-life costs are typically high relative to those incurred in preceding years. How our method accounts for these costs is discussed more thoroughly in GAO/HEHS-97-16.

eliminate variations attributable to state differences. We selected California because it covers 36 percent of all Medicare HMO enrollees and includes counties that in 1995 had the nation's highest HMO penetration rates. We found that our method could have reduced excess payments by more than 25 percent. Although better risk adjusters could further reduce the large remainder of excess payments, improving risk adjustment is a complex effort that may take years to implement full-scale.

The following key points also emerged from our analysis:

- First, for the counties that we analyzed, we estimated that total excess payments in 1995 amounted to about $1 billion (of about $6 billion in total Medicare payments to risk HMOs in the state). Applying our method for setting AAPCC rates would have reduced the $1 billion in excess payments by about $276 million.

- Second, the excess payments attributable to inflated AAPCC rates were concentrated in 12 counties with large HMO enrollment and ranged from less than 1 percent to 6.6 percent of the counties' total HMO payments, representing between $200,000 and $135.3 million.[16] Despite the size of these amounts, the application of our method would have produced relatively small changes in the monthly, per-beneficiary capitation payments, ranging from $3 to $38.

- Third, our analysis did not support the hypothesis, put forward by the HMO industry and others, that the excess payment problem will be mitigated as more beneficiaries enroll in Medicare managed care and HMOs progressively enroll a more expensive mix of beneficiaries. Our analysis–which includes data from counties with up to a 39-percent HMO penetration in 1995–indicated that the difference between Medicare rates and our rates is larger in counties with higher Medicare penetration. For example, the four counties with the highest rates of excess payment, ranging from 5.1 to 6.6 percent, were also among the counties with the highest HMO enrollment percentages in 1995.

Data Are Available to Enable HCFA to Promptly Adjust AAPCC Rates

Because the data we used to estimate HMO enrollees' costs come from data that HCFA compiles to update HMO rates each year, our method has two important advantages. First, HCFA's implementation of our proposal could be achieved in a relatively short time. The time element is important, because the prompt implementation

[16]For the state's remaining 46 counties, excess payments attributable to inflated county rates amounted to less than 3 percent of the 58-county total.

of our method would avoid locking the current methodological flaw into any adopted changes to Medicare's HMO payment method that continued to use current AAPCC rates as a baseline or fee-for-service costs to set future rates. Second, the availability of the data would also make our proposal economical: the savings to be achieved from reducing AAPCC excess payments would be much greater than the administrative costs of implementing the process.

RELATED GAO PRODUCTS

Medicare HMO Enrollment: Area Differences Affected by Factors Other Than Payment Rates (GAO/HEHS-97-37, May 2, 1997).

Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

Medicare HMOs: HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of County Payment Rates (GAO/T-HEHS-97-78, Feb. 25, 1997).

Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States (GAO/HEHS-96-63, Jan. 18, 1996).

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

(101566)

The CHAIRMAN. Thank you. Steve.

STATEMENT OF STEVE BRENTON, PRESIDENT AND CEO, ASSOCIATION OF IOWA HOSPITALS AND HEALTH SYSTEMS, DES MOINES, IA

Mr. BRENTON. Thank you, Mr. Chairman, committee members. I am Steve Brenton. I am president of the Association of Iowa Hospitals and Health Systems. We are a Des Moines, IA based trade association representing all of Iowa's community hospitals and emerging hospital-based health systems.

I have been asked to discuss current barriers to the development of Medicare health plans in Iowa, barriers which I believe also exist in most of rural America. I have also been asked to try to assess the potential for the emergence of Medicare health plans in rural America if an appropriate legislative fix can be fashioned by Congress in 1997. My message this afternoon is both simple and optimistic. I believe that reform of Medicare health plan payment will provide new opportunities for rural Iowa hospitals and physicians and new choices for rural Medicare beneficiaries. I very much believe that the impact of those developments will enhance the delivery of health care in rural America.

Because Congress has an historic opportunity to engineer structural reform of Medicare this year and since emphasis on market driven solutions appears sustainable as a bipartisan initiative, the issue of fair, equitable, and adequate payment rates looms as a priority challenge. But the opportunity for Medicare managed care to successfully emerge as an option in Iowa, in Nebraska, in the Dakotas, in Wisconsin, and other areas of rural America is negligible today and I believe will be minimal tomorrow unless the current payment formula significantly changes in 1997 by congressional action.

I earlier spoke of opportunities. Many of the community-based organizations which I represent do want the opportunity to directly contract health care to Medicare populations. Or they would like to have the opportunity to partner in risk sharing opportunities with existing insurers like Iowa's Blue Cross program. Discussions I have had with these folks, some of which were as late as last week, consistently point to the fact that payment rates, which in rural Iowa average less than $300 per month and in urban Iowa average less than $350 per month, just aren't adequate to develop risk business, let alone to finance new premium products with extra benefits which are necessary to attract senior enrollment, the kind of benefits that Mr. Running was talking about earlier.

I would like to outline five basic assumptions which I think summarize what is an overwhelming mandate for legislative action this year. No. 1, choice of health plans beyond the traditional Medicare program is good for seniors. The ability for seniors living in Jefferson, IA, in Wausau, WI, where my parents live, or Blair, NE, to enroll in no-premium health plans which provide perhaps a prescription drug benefit and a free health club membership is a good thing, much as it already is a good thing for their counterparts living in Phoenix, AZ and other areas of the country.

No. 2, the opportunity to own or to partner in Medicare risk business is a good thing for community-based health care providers.

No. 3, the absence of Medicare health plan opportunities in rural America relates primarily to low payment rates. No. 4, a point that Dr. Scanlon just made, I think, quite effectively, most of the payment differential is driven by medical practice and utilization patterns which are a product historic fee-for-service spending, not cost of doing business variations. No. 5, Medicare health plans will emerge in Iowa as early as 1998 if Congress acts in 1997.

My written statement outlines the parameters associated with a solution, a legislative fix to this issue. I know that a later witness is prepared to be more specific. I do believe we need to have a minimum payment floor adequate for health plan development in every county of the Nation, and I also believe we need to see a blended rate. That is a rate that over time is blended to recognize a larger degree of the national rate along with the local county rate. That blended rate over time will further dissipate variations that the minimum payment floor will not achieve. I look forward, Mr. Chairman, to questions if there are any. Thank you.

[The prepared statement of Mr. Brenton follows:]

IH&HS

ASSOCIATION OF IOWA HOSPITALS
AND HEALTH SYSTEMS

Medicare Equity Emerges As Crucial Issue for Rural Americans

Senate Special Committee on Aging

Dirksen Senate Office Building
Room SD-562

May 19, 1997

2:00 p.m.

Introduction

I'm Steve Brenton, President of the Association of Iowa Hospitals and Health Systems. The organization is a trade association representing all of Iowa's 120 community hospitals and emerging regional and statewide health systems.

Message: New Opportunities/New Choices

The message I'd like to leave with you today is a simple one...reform of Medicare health plan payment will provide new ***opportunities*** for Iowa hospitals and physicians and new ***choices*** for Iowa Medicare beneficiaries...and the impact of those positive developments ***will enhance the delivery of health care in much of rural America***. Achieving equity and fairness in Medicare payments should be viewed as the primary vehicle to bring Medicare choices to all regions of the nation, a goal my organization shares with other health reform advocates including the American Hospital Association and the Medicare Fairness Coalition.

Fairness and Equity: A Rural Health Issue

Fair and equitable payment is a rural health issue because most of rural America is plagued with a payment formula which is the product of low Medicare fee-for-service spending and conservative medical practice patterns. That payment formula is predicated on historic spending, not on historic or current costs of doing business and is now penalizing numerous, largely rural regions of the country in which reside millions of seniors who have ***no Medicare choices***, beyond fee-for-service.

Since I'm assuming that Congress, in debating major Medicare initiatives in 1997, will place heavy emphasis on market oriented solutions and on structurally reforming the program to achieve long term, systemic savings and encouraging managed care choices for seniors...the issue of adequate payment rates is huge, especially for health providers and seniors living in Iowa and other upper Midwestern states.

The opportunity for Medicare managed care to successfully emerge as an option in Iowa, Nebraska, the Dakotas, Wisconsin and much of rural America is negligible ***today*** and will be minimal ***tomorrow*** unless the current payment formula for Medicare health plans is significantly changed by Congress this year.

Provider Opportunities

Many of the folks I represent...hospitals and emerging health systems, want the opportunity to participate in direct contracting with the Medicare population...or partner in risk sharing opportunities with existing insurance companies like Iowa's Blue Cross plan. But that just won't happen unless the flawed payment system is fixed.

Discussions that I've had with these folks, as recently as last week, consistently point to the fact that current payment rates, which in Iowa average about $350 per month in urban areas and less than $300 per month in rural areas, are inadequate to develop "at risk" business, let alone finance new benefits, like pharmacy, which are necessary to encourage seniors to enroll in Medicare HMOs.

Assumptions

In looking at this issue, I'm making five assumptions:

1. Choices of health plans (running from the traditional fee-for-service program to a variety of HMO opportunities) is good for all Medicare seniors.

2. The opportunity to be owners of new health plans or partners with traditional insurance companies in Medicare risk products is a good thing for existing and emerging community-based provider organizations.

3. The absence of Medicare health plan activity in much of rural America directly relates to the low payment rates existing today in those counties. And, in fact, even in those areas of the country like Omaha, NE that have a couple of health plans open for business, those plans are only being marketed in adjacent counties with monthly rates in excess of $400 and the benefit packages available in those markets do not begin to compare to the generous "add-ons" found in markets with $500-700 monthly premiums.

4. Most of the payment differential between "high" payment areas of the country like Dade County, FL and "low" payment areas of the country like Winneshiek County, Iowa and Vernon County, Wisconsin relate more to medical practice and utilization issues than input

price issues. Hence, we have beneficiaries in certain parts of the country who, through an accident of history, are rewarded or penalized by a system which is not aligned to rationally move folks into a reformed Medicare environment.

5. Medicare health plans ***will emerge*** in Iowa and much of rural America as early as 1998, if Congress acts in 1997.

Guidelines for a Solution

Here are the parameters of an equity solution:

1. Establish a payment floor of at least 85 percent of 1998 USPCC effective January 1, 1998. This would provide a $425 payment floor in every county in the nation.

2. Further payment variations should be reduced through a blending formula which would reach 50/50 (county/national) after three years.

3. Ultimately, risk contracting should be de-linked from fee-for-service spending and moved to competitive bidding after geographic equity has been achieved.

4. "Hold harmless" proposals should be opposed as an impediment to achieving equity in a timely manner.

5. Reform of Graduate Medical Education is a fairness issue and a defined funding mechanism must be identified to ensure the appropriate education and training of future medical professionals.

Conclusion

I'm appreciative of having the opportunity to speak to this important topic. Seldom does an issue emerge which presents such an outstanding opportunity to improve the delivery of health care to rural seniors and I encourage your diligence in fashioning a solution that is fair and equitable to all stakeholders.

The CHAIRMAN. Thank you, Steve. Mr. Dillon.

STATEMENT OF DOUG DILLON, MEDICARE PROGRAM EXECUTIVE, PROVIDENCE HEALTH PLANS, PORTLAND, OR

Mr. DILLON. Good afternoon, Mr. Chairman, and members of the Special Committee on Aging. My name is Doug Dillon. On behalf of Providence Health Plans in Oregon and 33,000 Medicare members, I appreciate this opportunity to appear before you all to share some experience that Providence has had in Oregon in bringing needed benefits to our members, especially in rural communities. Providence Health Plans is a not-for-profit organization owned by Providence Health System, a not-for-profit organization, which is a fully integrated health system overseeing Oregon, Washington, Alaska, and California.

Our collective ambition is to serve and improve the health of the communities in which we serve. While we do not often talk about the accolades that we receive, to set a stage and a platform for further discussion, Providence was named as one of the top 20 health plans for quality measures by U.S. News and World Report this last year. Five of our hospitals are in the Top 100 list. Providence Health System was recognized as one of the five top integrated health systems in the country, and we were rated as one of the top 20 health plans in the country for member satisfaction. All this was accomplished with administrative costs of no more than 7.5 percent; 92.5 cents of every premium dollar received goes back into health care.

Capitated HMOs have a proven record in addressing the triple problem of cost, efficiency and quality. I feel that managed care is a better way to allocate the resources to improve the health of the communities in which we serve. I am here to speak to you today about the current AAPCC reimbursements that penalize Medicare beneficiaries in efficient medical communities and rural communities. Medicare HMOs are not affordable to Medicare beneficiaries in rural areas, and the current 50–50 rule is a barrier to Medicare risk products in rural communities.

First of all, the payment methods penalize Medicare beneficiaries and efficient medical models. The AAPCC rates for Oregon are well below the national average where our doctors have some of the shortest hospital lengths of stay and low admission rates. Efficient communities like Portland are penalized for the ability to manage costs well. In the Portland area, where 54 percent of all the Medicare beneficiaries are in one HMO or another, providers are implementing the care management techniques across all lines, whether they're on an HMO or a traditional Medicare fee-for-service with a supplemental, driving down the costs in the community.

Other cost conscious behaviors have resulted in Multnomah County where Portland is located having only a .39 percent increase from 1996 to 1997 as compared with a national average of 5.91 percent. The unfair difference in payment rates must be addressed. The phenomenon is especially true in the rural areas where spending lags way behind urban areas, which leads me to our most important message to you today: Medicare HMO members are not treated equally across the country. Providence Health Plans and other HMOs with low reimbursement rates are attempt-

ing to bring the broadest range of benefits they can to Medicare beneficiaries, but we are unable to bring the benefits such as dental, hearing, prescriptions and these kinds of benefits.

In Oregon, Medicare beneficiaries are charged up to $77 in monthly premiums. As Hans said, Providence Health Plans did go from $34.50 to $9.50 to zero in an attempt to provide broader access to Medicare beneficiaries so that they could enjoy the services other Medicare beneficiaries do across the country. In 6 months, we lost $1.2 million by attempting to do this, and then did return to a $19.50 rate this year and expect without any kind of reform increases again in 1998.

Over the last 10 years, I have virtually spoken with thousands of Medicare beneficiaries, and we have to answer the tough questions. When we first started, the questions were what is an HMO? Now we are getting asked, like some folks such as Hans, what is your AAPCC rate for Washington County or Multnomah County or the like? We have folks moving into Oregon from California that are asking us the same tough questions. I received all these benefits, and now I have to pay a premium? In rural counties where we are not, when we do enter and our rates are as high as $77 such as in southern Oregon, we are being asked the same tough questions.

The current 50–50 rule is a barrier to Medicare HMO risk contracts. Quickly, a health plan is required to have 1500 commercial members before you can start an HMO, and then you cannot enroll, have more than 50 percent of your enrollment be Medicare with combined Medicaid and Medicare taking into that account versus your commercial, and in urban areas, you have lower rates of commercial members, lower numbers, unemployment rates are higher, and we have to cut out our enrollment to Medicare members when we reach the 50 percent, and such is true in Oregon where in the Oregon Health Plan, the Medicare waiver program, the not-for-profit HMOs are pulling out of the Medicaid program and with the 50 percent rule being in place, we have had to shut or would have had to shut our enrollment to our Medicare beneficiaries. Thank you, Mr. Chairman, members of the committee. I appreciate this opportunity to share some of our thoughts with you all and welcome your questions.

[The prepared statement of Mr. Dillon follows:]

"BARRIERS TO OFFERING MANAGED CARE TO MEDICARE BENEFICIARIES THROUGHOUT OREGON"

Oral Testimony before the Special Committee on Aging, United States Senate.
Doug Dillon, Medicare Program Executive, Providence Health Plans in Oregon

May 19, 1997

Good afternoon Mr. Chairman and members of the Special Committee on Aging. My name is Doug Dillon. On behalf of Providence Health Plans in Oregon and our 33,000 Medicare beneficiaries, I appreciate this opportunity to appear before you today and share some of the experiences of our health plan, and barriers to bringing needed benefits to our members, especially in rural counties.

Providence Health Plans is a not-for-profit organization owned by Providence Health System, a not-for-profit integrated health system serving Oregon, Washington, Alaska, and California. Our collective ambition is to improve the health and quality of life for the communities in which we serve. We believe that we are making a difference:

- Providence was identified by U.S. News and World Report in 1996 as one of the top 20 HMOs in the country for quality measures.
- Five of our hospitals were rated among the top 100 in the country for efficiency and quality.
- Providence Health System was recognized in 1997 as one of the top 5 integrated health systems in the United States by Hospitals and Health Networks.
- Providence Health Plans was rated as one of the country's top 20 health plans for member satisfaction by the National Research Corporation.

And this was accomplished while operating our Medicare risk HMO with 7 and 1/2% administration costs.

Why We Are Here to Talk With You Today

Capitated HMOs have a proven record of positively addressing the triple problems of cost, quality and access for Medicare beneficiaries. We believe that managed care is a better way to allocate the resources to improve the health of the communities we serve.

I am are here to speak to you today about barriers we face in trying to offer managed care to Medicare beneficiaries across Oregon.

1. Current AAPCC payment methods penalize Medicare beneficiaries in efficient medical communities, and in rural areas.
2. Medicare HMOs are not affordable to rural beneficiaries.
3. The current "50/50 Rule" is a barrier to Medicare risk products in rural communities, and should be revised.

Current AAPCC Payment Methods Penalize Medicare Beneficiaries In Efficient Medical Communities.

As noted in Figure 1, Medicare AAPCC rates for Oregon counties are well below the national average because HMO AAPCC rates are tied to the prevailing fee-for-service costs in a county. Oregon providers are among the most efficient in the country, with the shortest hospital lengths of stay, and low admission rates.

Efficient communities (like Portland), are penalized for their ability to manage costs well.

In Portland, where 54% of all Medicare beneficiaries are on a Medicare HMO (which is the highest Medicare HMO penetration in the U.S.), providers are implementing care management for all of their patients, driving down costs in the community for Medicare members in traditional as well as HMO plans.

This and other cost-conscious behaviors have resulted in only a $1.50 increase (1996-1997) in the AAPCC rate for Portland in Multnomah County. This compares to an average increase of 5.91% in the U.S. This unfair difference in payment rates must be addressed.

The problem of AAPCC disparity is especially pronounced in rural areas. Per capita spending in rural areas lags well behind urban areas. The Medicare AAPCC rates in these rural counties are too low to make HMO options viable, unless higher premiums are charged to the Medicare beneficiaries in these rural communities.

This leads me to our most important message: Medicare HMO members are not treated equally across the country. Providence Health Plans, as well as other risk HMO plans in Oregon, are not able to provide the same level of benefits and low premiums at the current reimbursement levels that other beneficiaries enjoy across the nation. In many higher-cost counties in the U.S., benefits such as dental services, prescription drugs, hearing aids and others, are offered at $0 (zero) premium to the members.

In Oregon, Medicare beneficiaries enrolled in risk plans are charged premiums up to $77 per member per month depending on where they reside in the state.

In 1996, Providence offered a $0 premium plan in Portland so that Medicare beneficiaries could enjoy the same easy access to a Medicare HMO as beneficiaries in high AAPCC areas across the country. Although the benefit package was not as rich, Providence Health Plans still lost $1.2 million in just six months. We were forced to reinstate a monthly premium ($19.50) in 1997, and expect to raise the premium again in 1998.

Reductions in AAPCCs in already low AAPCC areas will likely result in reductions in benefits, increased copays and premiums, and more dissatisfied providers. As a result Medicare enrollees will move from managed care back to traditional Medicare.

Over the last ten years, I have spoken with thousands of Medicare beneficiaries who request benefit coverage for prescriptions, dental benefits, and hearing aids. Many of these people have moved to Oregon from such places as Southern California, where these additional benefits are frequently available at no additional cost to the Medicare HMO member. From the rural areas we hear questions like, "Why aren't you providing coverage in my county?" When we do open in a new rural county, we are asked, "Why are our rates so high, I didn't have to pay anything for my HMO in Arizona."

Medicare HMOs are Not Affordable to Rural Beneficiaries

Providence Health Plans is challenged to provide our health plan benefits in rural counties in an affordable way. Rural hospital and medical providers are inherently unable to achieve the same efficiencies as their urban counterparts. Many are struggling to keep their facilities and practices open. As a result, for example, we are finding that physicians are unwilling to accept the same levels of HMO payments as their urban counterparts. The only way in which we can implement Medicare risk contracts in rural counties is to charge high beneficiary premiums, which are unaffordable to many. Medicare beneficiaries in rural communities thus do not have an affordable alternative to the traditional Medicare program.

The Current "50/50 Rule" is a Barrier to Medicare Risk Products in Rural Communities

The 50/50 rule prohibits the start up of a Medicare risk HMO in an area, until a commercial membership of 1500 members is attained. In addition, the health plan's combined Medicare/Medicaid membership cannot exceed the health plan's commercial membership for that geographic region. This rule needs revision for the following two reasons:

1. This rule is a barrier for health plans when entering rural communities, because these areas tend to have older populations and higher unemployment. Thus, achieving 50% commercial enrollment is more difficult.

2. In Oregon, for-profit HMOs are pulling out of the Oregon Health Plan, our Medicaid waiver program. This is causing higher enrollment levels in the not-for-profit health plans which are then vulnerable to having their combined Medicare/Medicaid membership exceeding 50% of their total enrollment. As a result, these plans are forced to close enrollment to new Medicare Members.

Providence Health System recommends that the 50/50 rule be applied to the TOTAL enrollment of a health plan within a state, and not to each non-contiguous county in which they operate. In addition, because we are very concerned about the potential of further erosion of HMO participation in the Medicaid program, we would urge Congress to revise the 50/50 equation so that HMO Medicare membership cannot exceed the combined commercial and Medicaid membership.

In Closing

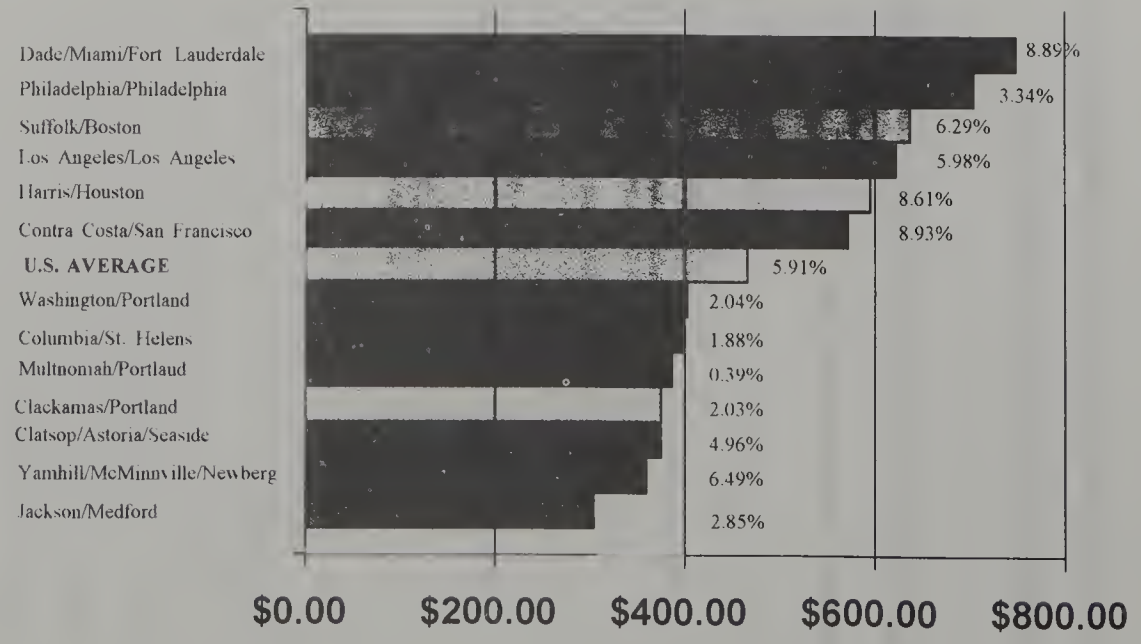
Clearly, Congress must reduce the crippling inflation rate in the Medicare program that we have experienced in recent years. However, we believe that states like Oregon are a model for providing cost effective medical care, and should not be penalized for their success. Across-the-board cuts will threaten the continuation of Medicare HMOs in efficient markets, and prohibit their affordability and expansion into rural communities. We believe Congress should take a national average blending approach in addressing the issue of the gross disparity between Medicare HMO payments. Significant Medicare payment equalization will support Medicare HMO growth into rural markets, as well as increase choice of health plans for all seniors.

Finally, we ask you to support HCFA's proposed changes in the regulation governing the application of the 50/50 rule, as we suggested earlier.

Thank you again, Mr. Chairman, for this opportunity to share our thoughts with you and the committee. I welcome your questions.

Figure 1

1997 Medicare Average Adjusted Per Capita Cost, and % Increase 1996-1997



The CHAIRMAN. You folks are all very disciplined. You all finished within the 5 minutes or less. I can hardly believe it. Thank you very much. Now to questioning. I will start with Mr. Brenton and Mr. Dillon. Concern has been expressed about whether increasing Medicare managed care reimbursement would have a negative effect on people on traditional Medicare. Some would say that right now we have a level playing field between fee-for-service and managed care Medicare because managed care rates are based upon fee-for-service. Since both of you represent hospitals as well as health plans, can you tell me if we are going to eliminate the option for fee-for-service medicine in rural areas if we increase the managed care payment rate?

Mr. BRENTON. Let me jump in first. I will take the easy part of that, and maybe Mr. Dillon can get the part that I did not respond to. The fee-for-service program is basically a function of cost of doing business in a county and also utilization and medical practice trends. In much of rural America and in areas that are considered to be efficient markets like Minneapolis-St. Paul, Portland, OR, Seattle, WA, areas where managed care has had a big impact, and much of rural America, you have low fee-for-service spending. The problem is when you use fee-for-service spending as a proxy for paying health plans, you have the kind of disparateness that we have been talking about today.

I personally believe that regardless of the fix that occurs this year, most Iowans for the next couple of decades will stay in the fee-for-service traditional Medicare program. I think that if Congress can fashion a good fix, you will see folks joining Medicare health plans. I think that is good. If we have a level playing field today, from my perspective it is pretty unlevel from the standpoint of the kind of geographic areas that are represented at this table. I think that moving away, as Senator Wyden suggested earlier, ultimately delinking fee-for-service from health plan payments is a long-term goal that hopefully Congress will move to.

The CHAIRMAN. Mr. Dillon.

Mr. DILLON. Mr. Chairman, I'd like to address the answer in two areas, one for the urban and one for the rural. In the urban area with the providers providing care across both the commercial and the indemnity or the supplemental world with traditional Medicare and HMOs, we still have approximately 10 percent of the population of the Medicare beneficiaries are not on any kind of supplemental plan or HMO plan. These folks are very low income. They do not qualify for the Medicaid program, and so for them to choose between being a part of a health plan and paying a premium, buying a prescription or eating becomes real choices for them. They have to choose.

By equalizing the AAPCC reimbursements and bringing equalization across the country and enabling efficient medical communities, such as ours, and communities that are dedicated to providing care to the communities in which we serve, and having a zero premium would bring equalization to those folks now and for rural areas. A recent experience of ours has been expansion into southern Oregon, into Jackson and Josephine counties. Two years ago into Jackson County, we had an artificially supplemented rate of $45. It is not the lowest reimbursed county in the State, but the

neighboring sister county of Josephine is. It is the lowest reimbursed county in the State, and we have just expanded there and are charging a premium of $77.

We feel that we are going to, because the Jackson County rate was artificially subsidized, we are going to have to raise that premium as well so both counties will be in the $70-plus premium. Again, we run into the same problems. Medicare beneficiaries just cannot afford those kinds of premiums without having to make choices whether to eat, buy prescriptions, or have health care.

The CHAIRMAN. We each know about the distress of rural hospitals and this is especially true in a State like mine of Iowa, where we have many senior citizens so that hospitals really depend upon Medicare money to survive. Many of them are hard hit by our efforts to reign in fee-for-service provider payments as we balance the budget. I would like to hear from each of you: Why do you think hospitals—let me put it this way—why do hospitals think that they will be better off if we reform the AAPCC?

Mr. BRENTON. I have actually had that question asked by some of my members who are wondering why I am spending so much time on this issue, wondering if they really do want managed care to come to rural America. My personal opinion is that we do for a lot of different reasons. We can no longer afford to sustain the growth in Medicare spending that we are finding in the traditional fee-for-service side of the equation. I believe that Medicare managed care will ultimately come to Iowa, perhaps slowly with or without substantial change, because I think that ultimately is the silver bullet that policymakers will choose to reign in health care costs.

So even for my rural members who very well may not own health plans or partner in health plans, I think it is far better that they be a vendor to a health plan that is receiving a $400 monthly rate than a health plan receiving a $280 monthly rate. That is kind of the cynic's viewpoint.

From a positive perspective, our rural community hospitals are only as good, only as effective, as the folks that they represent and serve. I think that serving folks who have choices tomorrow who today have none is overall a good thing for rural hospitals and rural physicians.

The CHAIRMAN. Mr. Dillon, how about rural northwest United States? Would you differ in any respect from what Steve has said about the Midwest?

Mr. DILLON. In the Northwest, and I had the discussion with one of our hospital financial folks, the hospital folks in their agreements with the HMOs are already taking discounts that go below what the traditional Medicare fees would pay them, and so for our own, Providence Hospitals, for instance, are taking upwards from ten to 20 percent lower reimbursement at this point in time in their arrangements with the Medicare HMOs.

The CHAIRMAN. Would they be getting more business as a result of being in the HMOs than if they were fee-for-service?

Mr. DILLON. The hospitals would not necessarily be getting more business. It would be dispersed in the avenues in which the folks come to them. There would be more business from the folks that may put off a hospitalization or an elective surgery or things of

that nature because they don't have access to health care. Again, they have to make their choice until it becomes an emergency situation.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. I want to thank the panel very much for setting out the problem. Finding the answer is the real difficult task. You know it is almost like the chicken or the egg story as to which comes first here. Some have said that the principal barrier to HMO enrollment is not the payment rate so much as it is the fact that there are fewer people and only a few HMOs in a particular area. Others would argue that there are fewer HMOs in an area because of the payment rate. So I mean it depends on where you come from as far as what you think is causing the problem.

I guess my question is can we fix this problem now by somehow delinking the HMO payment rate to the fee-for-service figure in the areas or should we continue to have it linked together?

Mr. SCANLON. I think we can make progress by partially delinking the HMO rate and the fee-for-service rate. We have seen that, with the close linkage between the two, in rural areas we have no HMOs. We need to recognize that there are additional costs to operating in a rural area. There, an HMO does not have basically the economies of scale. They cannot spread their administrative costs over a large group of people. They have to go outside of their own network often to secure specialty services, whereas an HMO in an urban area may be able to have specialists within their own network. This does not give them as much leverage in terms of negotiating discounts and controlling utilization. So I think we need to recognize that. At the same time, I think we have to be sensitive to the fact that, as Senator Grassley indicated, we do not want to uneven the playing field so much that we have seriously handicapped the fee-for-service sector in communities so that the few HMOs that are there have incredible leverage over existing providers and affect their well-being too much.

Senator BREAUX. What about risk adjustment for the HMOs? At present we adjust for gender and age, but not health of individuals enrolled in HMOs. An HMO obviously that has healthy seniors and younger seniors has a lot less costs than HMOs that may have, if you can find one, that has older seniors who are not healthy as much, and yet the reimbursement rate does not take that into consideration.

Mr. SCANLON. It certainly is. The fact that we are not able to adequately adjust for differences in health status contributes greatly to the overpayments that we measured in California in some recent work. In fact, three-quarters of that was due to the failure of what is known as the risk adjustors in adjusting for health status.

Senator BREAUX. Who would be better off if we risk adjusted HMO payments?

Mr. SCANLON. In terms of areas or in terms of any——

Senator BREAUX. Well, I mean would the HMOs benefit?

Mr. SCANLON. The HMOs would generally not benefit, but I think the program overall would benefit. We would be able to sustain sort of a stronger managed care program and a stronger Medicare program over time because at this point we are not saving money by encouraging people to join managed care plans.

Senator BREAUX. Mr. Brenton, you have suggested in one of your suggestions a floor of $425 per person for an HMO enrollee. It is an interesting suggestion, but would it not have the potential for creating higher HMO reimbursements than some fee-for-services in an area? I mean you got some areas where the fee-for-service would be substantially less than that.

Mr. BRENTON. Yes. Yes, it would. But I think——

Senator BREAUX. How does that help solve the problem? Indeed, it is probably pretty good news for a few HMOs that would be getting paid a lot more than for the fee-for-service in the area.

Mr. BRENTON. I think a good example would be the HMOs that are operating out of Omaha, NE, and Omaha has a rate right now of a little bit over $400, and I think Mutual of Omaha, and believe U.S. Healthcare have Medicare HMO product in those markets. They are only offering that choice, that option, to seniors in Omaha, and two adjacent counties. They are only offering those products because those three counties have rates high enough to instill the kind of market support for HMO activity. They are not offering HMOs right now in markets below $400, and I don't think they will because those companies have made a business judgment that they cannot offer an attractive enough health plan and make a few dollars doing so to get seniors interested in leaving the fee-for-service side of the equation to join that HMO. So ultimately no one is going to force seniors into these products even if they do exist.

I think that we will have product offerings across the nation, which would be my goal, if in fact we could surpass the $400 average payment rate.

Senator BREAUX. Well, my time is up, but I would just make the comment, I think all of this just points to, in my opinion, what I have become convinced of, which is the inability of Washington to fix prices in the health care field. Medicare tries to fix prices on how much we are charging, and we are doing that, and now we are trying to base HMO reimbursements on 95 percent of these prices, and it is just a band-aid approach that is not going to work. We need something broader and more in the terms of overall reform. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wyden.

Senator WYDEN. Thank you, Mr. Chairman. Mr. Chairman, I think it has been an excellent panel and I have a couple of questions. Let me begin with our provider groups. Some say that HMOs are engaging in widespread cream skimming, in effect, just trying to take healthy folks. How would you respond to that argument about HMO practices?

Mr. DILLON. I would say from Providence Health Plans and Providence Health System that we truly have not seen that to be the case across the community; that there are folks that still require the hospitalizations. We are not seeing that there is an unusually healthier risk that we are seeing as membership. We are seeing that the physicians are better able to effectively manage the care of the people that we are seeing so they can get ahead of the ball, so to speak. For the folks that are significantly sick, they will require hospitalization and skilled nursing facility care and the like. As I say, we are not seeing that, but physicians being in a place

to better manage the care can take care of those problems up-front effectively and take the steps necessary to keep folks healthy rather than allow them to get sick and bring them back to a level of health.

Mr. BRENTON. We have no Medicare managed care in Iowa. We have only modest commercial managed care. Beyond—I really have no personal experience beyond anecdote on that topic. I am personally optimistic that the kind of Medicare health plans that will emerge in Iowa will either be owned by providers or in most cases be partnerships between community-based providers and Blue Cross, for example, or John Deere Health Plan. I am hopeful that that kind of community focus will at least minimize the kind of cream skimming that one reads about or one hears.

I think Oregon has largely been the kind of model that I would like to see emerge—Oregon and also the Minneapolis markets—the kind of models I would like to see emerge in Iowa over time. I think both of those markets have a reputation for avoiding the kind of cream skimming that you are referring to.

Senator WYDEN. I am anxious to work with both of you on this. I introduced comprehensive Medicare reform legislation earlier this year. In that bill, we include what is known as a coordinated open enrollment fair, a concept that would ensure that all the plans were essentially there and making their coverage available as a way to get away from some of the prospective and selective marketing. Clearly, this is going to be an important issue in the whole debate, and I think it is essential to look at many approaches. Coordinated open enrollment may not be the only viable policy option. In general, I believe that we will hear much about selective marketing—people will buy health lists and this kind of list. I think selective marketing is an issue that has got to be dealt with. I thank you for an excellent presentation.

Mr. BRENTON. Thank you.

Senator WYDEN. Mr. Running, I thought you discussed the problem well in an Oregonian article. I think Medicare needs to be reformed not because it has failed, but because it is a great program that should not be undermined by the outdated purchasing practices that you described. Since my days with the Gray Panthers, I have gotten calls from seniors in Hillsboro or different parts of Oregon about this issue. I talk to my cousins in Los Angeles and they talk about their free drugs and their free eyeglasses and their free hearing aids. What is your sense about this issue after talking to seniors around the country since that Oregonian article was published? Is this approach undermining public confidence in the program?

Mr. RUNNING. Well, I think the biggest undermining is done by specialists, orthopedic surgeons, urologists and so on. Boy, they are poisoning people with regard to wanting to belong to an HMO. They have lost their clout that they once had where they were able to almost dictate specialties and what they were doing. Now they have somebody looking over their shoulders. I think that is the biggest deterrent to people.

Senator WYDEN. Well, I thank you all. It has been a good panel, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you. Senator Hagel.

Senator HAGEL. Mr. Chairman, thank you. I echo Senator Wyden's compliment to the panel. It has been excellent. I know we do not mean to pick on our two panelists at the end of the table here, but, Mr. Brenton, when you come before any congressional committee with guidelines for a solution, you know we are going to pay attention and ask you a lot of questions, and you have five guidelines for a solution. I would like to delve into a couple of them, and really all four of you have touched on each of the five areas. But one in particular, the payment formula, the elusive payment formula. What do we do about a payment formula? You talk about a blended formula in part two of your guidelines for a solution. Would you care to enlighten us a little bit on what you mean and how we could frame this?

Mr. BRENTON. Sure. Basically there are any number of models, and I know that there is an expert following me that will be far more articulate than I am on this issue. But the idea of a formula basically is to take the national rate, let us say that it's $500—it will be pretty close to that on 1–1–98. You then take your local rate, which I guess you have one in Nebraska in the low 200's, and over a period of time you move toward a 50–50 blend between that local rate and that national rate. In some cases, that blend will be obviated by whatever floor you establish. Or the blended rate will not kick in until you surpass that floor.

But the basic concept is you pick a period of time, 3 years, 5 years, and you move from what is now totally a local rate to at the end of that period of time having a rate that is 50 percent local, 50 percent national. That is a way in part to deal with this cost of doing business issue versus the medical practice and utilization differences.

Senator HAGEL. All the things that we have heard today from you and the other panelists will help get us there if we, in fact, would implement that?

Mr. BRENTON. Yes. Absolutely. I believe that.

Senator HAGEL. Incidentally, Douglas and Sarpy County are the two counties in Nebraska, and I think Douglas is somewhere around $432 a month and Sarpy County actually is below that, $375, something to that effect. You also mentioned that Medicare health plans will emerge in Iowa and most of rural America as early as 1998 if Congress acts in 1997.

Mr. BRENTON. Yes.

Senator HAGEL. Where would you begin acting so that we can ensure that Iowa and Nebraska and the rest of the States represented here have that option in 1998?

Mr. BRENTON. I can speak for Iowa. I cannot speak for the rest of the Nation when I make that prediction that something will happen as early as 1998. I think establishing a reasonable payment floor, and I have a suggestion which some might suggest is a bit optimistic, but I believe a rate of $425 would have a huge impact in 1998, followed by a blend. I believe in Iowa, our Blue Cross plan, in partnership with a number of major provider systems, and at least two other plans that I know of will emerge statewide with a fix of the type that I outline here. I feel very confident having had discussions with those folks that they are set to go. What they are

waiting for is an adequate payment rate to make it worth their while to take a risk in these markets.

Senator HAGEL. Mr. Dillon, would you like to add anything to any of this?

Mr. DILLON. Mr. Brenton really stated the difficulty and the solution quite well. For Oregon purposes, we are a little bit beyond not having HMOs in rural areas. We are starting to expand in rural areas in nine counties in central Oregon with some rather low AAPCC rates. We will be expanding. However, the premiums that we will be charging in those areas will be in excess of $70, and there are other demands that are placed on health plans that have not come up at this point in time besides the need by Medicare beneficiaries. The other demands are coming from employer groups, large national employers, or regional employers, that are saying, yes, we want to cover our retirees with managed care. The pressure on us to move into those new areas and those new markets.

Senator HAGEL. If I may for a moment, Mr. Dillon, I want to quote something out of your testimony when you talk about the AAPCC payment methods. You get down here and you say Oregon providers are among the most efficient in the country with the shortest hospital lengths of stay and low admission rates. Is that a result of all the things that you are talking about, more control, more flexibility, as to why you find yourself in Oregon providing these kinds of services with this kind of very attractive outcome?

Mr. DILLON. Yes. With the role of our primary care physicians being as important as it is, being able to manage the care effectively up-front, we have been able to hold down our lengths of stay. We have under a thousand days per thousand as compared——

Senator HAGEL. I am sorry. Under a thousand days?

Mr. DILLON. Per thousand. You take a thousand members and the number of days that they are admitted or in a hospital reached a certain number, and this would compare very much competitively with some other States in the country where utilization is not as strong or HMOs have not penetrated the market, where it is much lower than our 54 percent. It may be down around 20 percent penetration in the days per thousand and hospital admissions might be over 1500.

Senator HAGEL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hagel. Senator Feingold.

Senator FEINGOLD. Thank you, Mr. Chairman. I just want to mention it is good to see Mr. Brenton again.

Mr. BRENTON. Good to see you.

Senator FEINGOLD. Wisconsin's loss has been the Chairman's State's gain. We worked together a lot when he was in Wisconsin.

Mr. BRENTON. We sure did. Thank you.

The CHAIRMAN. Yes.

Senator FEINGOLD. I wonder if Mr. Brenton and Mr. Dillon would expand a little bit more on the issue that so many of us have been talking about, the impact on rural areas if we fix these problems of the inequities. I understand that some at least have said, and I do not think it is the majority view, but some have said that increased HMO activity in rural areas will exclude the physicians and hospitals and other providers that are already providing serv-

ices in rural areas. I think it is important to have your response on the record to that one more time.

Mr. BRENTON. Certainly I would not be here as a hired gun for Iowa hospitals if I felt that what I am articulating needs to be done would, in fact, lead to excluding community-based hospitals or physicians. In fact, I believe that although they are a bit trepidatious, that many of those community-based hospitals and physicians want to be major players. They want to be partners with health plans that rationally manage care with a community perspective. They cannot do that today.

I think one of those charts had Vernon County, which up until last year may have been the lowest paid county. Now, Nebraska has one a bit lower. Nothing can happen until this issue is dealt with. I think basically what we are looking at, and probably from a short-term perspective, there may be a more positive impact on the beneficiary side than on the provider side. But I think long-term, the two will come together and overall having choices that are not available today with some kind of fix will be positive for beneficiaries in rural America as well as the providers who have served them well for many years.

Senator FEINGOLD. Mr. Dillon.

Mr. DILLON. I found a similar situation in our expansion into nine counties in central Oregon, very, very rural, high desert, many thousands of square miles where very few folks live, and the hospitals are few and far between, as are the providers. What we have found is that providers want to partner with us, both in the bringing of the commercial plans and now the Medicare plans. They want to become partners. They see that managed care works, that it works both for them and for their patients and members, and that together we can work in very cooperative venture to improve the health of the folks that live in their community. So we have not met with obstacles, and, in fact, the provider groups in some rural communities such as southern Oregon, there may be several different IPA's, have all wanted to come and partner and be a part of this. They see that managed care is coming.

Senator FEINGOLD. Thank you. I have one other question for both of you. In an effort to bring more equity to the current formula, a number of proposals would phase in a blended local and national rate. In my view, a lot of those proposals do not actually go fast enough or far enough. When my constituents ask me why they continue to be denied access to managed care alternatives that include an appropriate equitable level of benefits, and why their premiums continue to subsidize benefits in other parts of the country that are far beyond what market differences would justify, what do you suggest I tell them for the record?

Mr. BRENTON. My parents who are constituents of yours in north central Wisconsin have asked me that very point with examples and anecdotes from Arizona where they spend a few months each year and from California where they have relatives. My response to them is to make sure that Senator Feingold and Senator Kohl and Congressman Obey and others are on board supporting an appropriate bipartisan fix to this issue in 1997. If that occurs, I believe they will have the kind of choices, maybe not quite the choices

that include the benefit levels that Senator Wyden referred to earlier, but I think they will have choices soon.

Senator FEINGOLD. Mr. Dillon.

Mr. DILLON. I would say that along with Hans who has kept me in my place over the years, and asked me, was the first one to ask me what the AAPCC is for a given county, the other folks that are members of my plan that I have daily if not weekly contact with are my mother and father-in-law who are on this health plan. Before coming here, my father-in-law asked me what is it you are going to speak to members of the Senate on the Special Committee, and when I told him, and we had conversations about the equalization of the AAPCC, he says you are kidding. I did not know that. So as Senator Wyden was saying earlier about his remembering the days of the Gray Panthers and catastrophic Act bill and the like, as knowledge is out there, the more contacts, the more frequent phone calls and letters that I believe you all get. In terms of answering the question, I would say you are on board with bipartisan decision for equalization of the AAPCC, and in terms of having a national blended average and a floor.

Senator FEINGOLD. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. I am going to ask my colleagues to forego a second round of questioning because of the Budget Committee meeting at four o'clock, and dismiss the first panel with a big thank you for your contribution to this discussion and a contribution to what I think will be a successful resolution of this problem so that we will be able to have this equity and fairness and quality of care in rural America that we have in a lot of other areas of the country. It is going to be a major thrust of the members of this committee, and Senator Breaux and I are on the Finance Committee together to make sure that this issue is worked out. So I thank you for your contribution.

I call the second panel to address ways to increase choice and equity in the Medicare program by reforming the payment system. Our first witness is Susan Foote. Ms. Foote is president of the Coalition for Fairness in Medicare, a former professor at the University of California at Berkeley, and a former staffer on health care issues here in Capitol Hill.

Dr. David Colby is deputy director of the Physicians Payment Review Commission, and our final witness is Dr. Kenneth Thorpe. Dr. Thorpe is a professor at Tulane School of Public Health and Tropical Medicine and a former deputy assistant secretary for Health Policy, HHS. We will start with Ms. Foote, Dr. Colby, and Dr. Thorpe.

STATEMENT OF SUSAN FOOTE, PRESIDENT, COALITION FOR FAIRNESS IN MEDICINE, WASHINGTON, DC

Ms. FOOTE. Thank you very much for the opportunity to testify. My name is Susan Bartlett Foote, and I am the Washington Coordinator for the Coalition for Fairness in Medicare. Before I begin, as a former staffer, I would be remiss if I did not offer a special thanks to the staff of this committee for their hard work in putting this hearing together.

The Coalition for Fairness in Medicare is a very diverse group which is rare in this town of state hospital associations, individual

hospitals, HMOs, state Blue Cross/Blue Shield plans, rural referral centers and physician organizations. We came together in 1995 to address the serious consequences of the payment inequity that this committee is looking at today. I have been asked to speak about solutions and I have to say that the first panel was so effective in describing the problem that there really is not any need to spend time on the problem, but I would like to spend a minute on terminology.

The AAPCC is really just an acronym that expresses the monthly premium payment that Medicare pays. In the program today, only HMOs are allowed to receive that Medicare premium payment, but other forms have been discussed such as physician sponsored organizations, which also could be premium-based options. Some members have also talked about indemnity style or fee-for-service type premium based plans. So the real issue is simply how to establish a fair Medicare premium payment, and then the issue will be what kinds of organizations can offer health plans with that premium. You can compare that to the traditional Medicare, which I like to think of as simply a government bill-paying service. Medicare pays the fees that the physicians and hospitals charge.

In order to look at solutions, I want to refer to two charts. The first one we have talked about. That is the "before" chart. The color-coded map illustrates the wide variation, which has been pointed out, as really driven by utilization patterns in the underlying fee-for-service marketplace, and that is clearly the flaw that we have to deal with. I just want to give a couple of utilization figures so you can keep these in your mind relevant to the areas we have been talking about. In Dade County, Part B spending in the fee-for-service side, that is just the doctor side alone, not counting hospitals, is $363 per person per month. That is more than Nebraskans spend for hospitals and doctors in all but the two counties that you mentioned.

The second chart, I think, is the most effective for seeing where we need to go. This chart, and let me explain it, compares the variation. The purple line at the bottom is the variation in the FEHBP HMO premiums that are charged to Federal employees. The green line, which we like to call the heart attack line, is the AAPCC, or the Medicare premium, you probably cannot see those, but in the testimony we have a copy of that chart. That is the variation in AAPCC's. The gray line in the middle is the average payment.

Now, clearly when you are talking about the Medicare population, more dollars are going to be spent. That is why the gray line is higher than the purple line. But the point is comparing the variation because in real markets, and the FEHBP is based on markets, where the government demands the best price that is available for the commercial sector and that is what they get, the variation is quite slight. I have been told by HHS that most of the variation is around 6 percent regardless of where you are with some outliers, but it is around six, maybe 10 percent maximum variation.

But the AAPCC is, as you can see, wildly disparate. The question is how do we go from the green line to a line that looks more like the purple line, and that is the solution. The solutions are not hard, and, in fact, many of them are familiar to those of you who

have worked on problems in the Medicare program in the past. But first and foremost, and Senator Wyden mentioned it, it is absolutely essential to delink or decouple the premium payment from the underlying fee-for-service side. You've got to break the habit. That is the first step.

The second, as we have referred to, is to normalize or reduce the variations through a blending formula, but it is important to note that Congress has done this before. In the 1980's, in the dealing with the hospital DRG's, the original Medicare program paid reasonable and customary charges, but those charges were all over the map. Over a course of a 10-year period, the rates were blended in the DRG program to reduce the variation. So now the variation for hospitals is based on input prices alone. So it is a very familiar tool which HCFA is accustomed to using. There was a good deal of squawking in the beginning of DRG blending, as you might imagine, and there will be squawking as that blending process begins, but the system adjusted to the more equitable rates. So the issue for you, as Senator Feingold mentioned, is simply how fast and how far do you go?

The third point I want to make is on the payment minimums, which are especially important for members in rural areas, and I like to call those a down payment on fairness. Oh, I am running out of time.

The CHAIRMAN. Proceed.

Ms. FOOTE. Thank you. Under the current system, as we have heard, there are no choices in rural areas because the so-called premium payment is inadequate, and there are no options available, but what is this low spending? The low spending reveals what rural health care experts have always known: that in these areas, rural citizens are underserved. They are not getting all the care that they are entitled to get under the Medicare program. A properly financed physician sponsored organization, HMO, or other premium-based plan would have to, in order to get licensed by Medicare, ensure that all the specialty care and all the tertiary care that an individual is entitled to would be received, but you cannot do that in a fee-for-service marketplace where there are no specialists available.

A network, which is what Mr. Brenton was talking about, would allow that care to be organized with an adequate premium, and the care would be received. So, yes, indeed, there would be more spending in rural areas, but that is a good thing. We are talking about redistributing the resources so that everybody gets an adequate Medicare benefit. These three reforms can all be accomplished within the savings targets that the budget resolution in a few minutes when you determine it will establish. It is a matter of projecting the allowable per capita growth rates and redistibuting dollars over time in a fair and more equitable fashion.

These tools are transitional, and they are clearly not, as Senator Breaux indicated, a final solution. Congress still must work to explore effective ways to use the competitive process to save money, and Congress still needs to worry about people like me, the baby boomers, when we retire in the next 15 years, but these three reforms can be done now, and they can be done as part of a bipartisan budget deal. As a result, you will restore the promise that

Medicare, which is financed by all of us, will serve all of us in the future regardless of where we choose to retire. Thank you.

[The prepared statement of Ms. Foote follows:]

COALITION FOR FAIRNESS IN MEDICARE

Statement of

Susan Bartlett Foote
Washington Coordinator
The Coalition for Fairness in Medicare

Before the

Special Committee on Aging
United States Senate
Washington, D.C.

Monday, 19 May 1997 - 2:00 p.m.

Susan Bartlett Foote
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Statement of

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The Coalition for Fairness in Medicare

Before the

Special Committee on Aging
United States Senate
Washington, D.C.

Monday, 19 May 1997 - 2:00 p.m.

HOW TO GET FROM HERE TO THERE REFORMING MEDICARE'S AAPCC

WHO WE ARE

Thank you for the opportunity to testify before you today. My name is Susan Bartlett Foote. I am the Washington Coordinator of the Coalition for Fairness in Medicare.

The Coalition for Fairness in Medicare is an ad hoc group of over thirty hospital systems, Health Maintenance Organizations [HMOs], physician groups, state Blue Cross plans, and national associations who share a common goal: equity and fairness in Medicare capitated payments.

A list of the current members of the Coalition follows. Some members have offered Medicare risk contracts for many years, and others would like to have the opportunity to offer a premium-based Medicare product in the future.

The Coalition for Fairness in Medicare

The Coalition for Fairness in Medicare is an ad hoc group of hospital systems, HMOs, state hospital associations, and provider organizations who share a common goal -- **equity and fairness in Medicare payments**. The Coalition was born in early 1995 when three Minnesota health plans saw the need to address the payment inequities as Congress debated Medicare reform. The group expanded rapidly as health plans and other provider groups realized that fair payment was the only way to ensure choices of health plans with a wide range of benefits in all regions of the country.

Allina Health System
Minnetonka, MN

American Academy of Family Physicians

Association of Iowa Hospitals and Health Systems

Aurora Health Care
Milwaukee, WI

Blue Cross of California/WellPoint

Blue Cross of Idaho

Blue Cross of Washington/ Alaska

Blue Cross and Blue Shield of Arizona

Blue Cross and Blue Shield of Colorado

Blue Cross and Blue Shield of Iowa/South Dakota

Blue Cross and Blue Shield of Kansas City

Blue Cross and Blue Shield of Minnesota

Blue Cross and Blue Shield of Oregon/Legacy Health System

Blue Cross and Blue Shield of South Carolina

Blue Cross and Blue Shield of Wisconsin

Empire Health Services -
Spokane, WA
Deaconess Medical Center
Valley Hospital/Medical Center

Group Health Cooperative of Puget Sound - *Seattle,WA*

HealthPartners
Minneapolis, MN

Inland Northwest Health Services - *Spokane, WA*
St. Luke's Rehabilitation Institute

Intermountain Health Care
Salt Lake City, UT

John Deere Health Care
Moline, IL

Kansas Hospital Association

Kapiolani Health Care System
Honolulu, HI

Maine Hospital Association

Minnesota Hospital and Health Care Partnership

Montana Hospital Association

New Mexico Hospitals and Health Systems Association

Oregon Association of Hospitals and Health Systems

PeaceHealth Corporate Center
Eugene, OR

Physician Partners, Inc.
Portland, OR

Providence Services -
Spokane, WA
Sacred Heart Medical Center
Holy Family Hospital

Rural Referral/Sole Community Hospital Coalition

Saint Agnes Medical Center
Fresno, CA

Sisters of Providence
Seattle, WA

South Dakota Association of Healthcare Organizations

UCare Minnesota
Fairview Hospital and Healthcare services

Utah Association of Health Care Providers

Washington State Hospital Association

Welborn Clinic
Evansville, IN

Wisconsin Health and Hospital Association

Wyoming Hospital Association

Monday, May 12, 1997

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WHY REFORM IS NECESSARY

There is widespread agreement that the methodology to pay Medicare's HMOs is seriously flawed. Among the flaws include the extreme variation in payment from county to county. The consequences of this variation are limited choices for beneficiaries in low payment areas and inequity in the benefits available to beneficiaries based on geography.

The Coalition for Fairness in Medicare urges Congress to reform this payment methodology in order to improve the choices of beneficiaries and provide equitable distribution of Medicare resources. We appreciate the need for fiscal restraint in the Medicare program. We believe that fair payment can be achieved in a budget neutral manner or even while saving dollars over time. In fact, we believe that the success of reform proposals depends upon addressing the dramatic regional variation in Medicare capitated payment rates.

It is important to remember that HMOs are the only type of health plan that is currently allowed to offer a premium-based alternative to traditional Medicare. Congress is currently considering allowing other types of plans, such as Physician Sponsored Organizations [PSOs], to offer plans to Medicare beneficiaries. There is no reason why Congress could not allow all the many alternatives available in the private marketplace to Medicare beneficiaries. However, no alternatives can flourish without a fair and equitable way to calculate the federal premium payment.

This testimony will provide a brief background on the reasons for the geographic inequities, and then will describe proposed solutions to the problem. Relatively simple tools, which are familiar to the Health Care Financing Administration [HCFA] and have been used in the past to correct inequities, can solve the problem. The solutions we propose offer a smooth transition from the dramatic variation in current payments to a payment methodology that reflects the costs of care for the Medicare entitlement package in the market in which it is offered. Reform will restore the promise of Medicare coverage while offering choices in a competitive environment for all Americans, regardless of where they retire.

BACKGROUND: HOW THE AAPCC WORKS

In 1982, Congress gave seniors the opportunity to choose either traditional fee-for-service Medicare or enroll in a new HMO alternative called a TEFRA risk contract. Fee-for-service Medicare operates like a bill paying service. The beneficiary seeks care, the doctor or hospital sends the bill to Medicare for payment. In contrast, an HMO receives a monthly premium payment. The health plan is obligated to provide all the Medicare benefits. The health plan takes the risk of all the costs of care a beneficiary is entitled to receive.

The challenge was to design a way to set the monthly premium payment. Congress reasoned that HMOs were supposed to save money, so they would pay them less than the sum total of the spending in the fee-for-service side of the program. Starting with the historic fee-for-service costs, HCFA calculates an average rate called the United States Per Capita Cost [USPCC]. It then calculates separate premium rates for each county. Through a series of steps, HCFA derives what is known as the average adjusted per capita cost [AAPCC] which reflects various demographic adjusters and includes Part A hospital spending and Part B physician and outpatient services. Health plans are paid 95 percent of that rate.

If an HMO chooses, it can add additional benefits not covered by traditional Medicare, such as pharmaceutical, dental, eyeglasses, for example. The higher the payment rate, the more likely it is that a plan will add desirable additional benefits. When payment rates are low, there are fewer additional benefits and often monthly premiums in addition to the Part B premium all beneficiaries must pay.

WHY ARE THERE EXTREME VARIATIONS?

The color map of the United States on page five provides an arresting illustration of the extreme variations in spending from county to county in the United States.

The average payment per capita in the program is $467 per person per month in 1997. However, Medicare spending in many rural counties falls well below $300 per person and in some areas can be as high as $767 in New York, New York and $748 in Dade County, Florida. However, not all urban areas are high: there are urban markets like Portland, Oregon [$375], Seattle, Washington [$428], and Milwaukee, Wisconsin [$434] that fall far below that of other cities, and well below the national average.

We cannot solve this unless we understand its causes.

How Do United States Counties Compare with the National AAPCC Average of $467?

$326 or Less		31% - > BELOW
$327 to $373		21% - 30% BELOW
$374 to $420		11% - 20% BELOW
$421 to $467		10% - < BELOW
$468 to $517		10% - < ABOVE
$518 to $564		11% - 20% ABOVE
$565 to $611		21% - 30% ABOVE
$612 or More		31% - > ABOVE

▷ Costs of Care Cannot Explain the Variation

Prices for medical services vary slightly from one area of the country to another. However, different prices for services and different input costs cannot explain the 300 percent variation in spending from county to county. Honolulu, Hawaii is the most expensive city in America, yet its AAPCC is only $382, 18 percent below the national average of $467.

The chart on page seven helps illustrate that the cost of care cannot justify the differences in payment.

The bottom line shows the prices paid for HMOs in the Federal Employee Health Benefits Program [FEHBP]. Note that the variation from area to area is quite small. Most of the variation in the FEHBP premiums is only six percent, according to the Department of Health and Human Services. These plans reflect the best price in the community as measured by what employers pay for care.

Contrast that to the highly variable AAPCCs in the same communities.

The chart shows that the actual dollars spent are higher on average because the Medicare beneficiaries are far older than the younger federal workers. Input costs cannot explain this difference. To the extent that input costs do vary, adjustments can be made to accommodate them.

Comparing the Variation.
1997 Medicare and Federal Employee HMO Premiums

▷ Health Status Cannot Account for the Variation

Rural health care spending in Medicare is uniformly low, which accounts for the low AAPCCs. However, rural health indicators show that rural elderly have lower per capita incomes [16.5 percent of rural elderly are below the poverty line as compared with urban elderly at 12.4 percent]. Poverty is a reliable predictor of poor health status. Rural elderly suffer from more chronic conditions and have lower rates of Medigap or private retirement supplements. There is simply no evidence to support a conclusion that elderly citizens in urban Louisiana, for example, need more than twice as much care as Louisiana beneficiaries in rural areas.

▷ Utilization Explains the Differences

Clearly the real factor here is utilization patterns, or the way medicine is practiced from area to area. Variations appear to reflect the underlying infrastructure of supply of hospital beds, physicians and specialty services. The excellent research work of John Wennberg at the Center for the Evaluative Clinical Sciences at the Dartmouth Medical School supports this conclusion. In *The Dartmouth Atlas of Health Care*, the variation in supply explains the utilization patterns.

For example, the average number of hospital beds per thousand residents in the United States is 3.3. Jackson, Mississippi has 4.7; Newark, New Jersey has 4.7, Chicago, Illinois has 4.6, and New Orleans, Louisiana has 5.2. By contrast Seattle, Washington has 2.4; and Honolulu, Hawaii has 2.2. It is no accident that Part A hospital spending is significantly higher in regions with large numbers of beds, many of which are underutilized.

Physician supply can also account for spending patterns in Medicare fee-for-service. Dade County, Florida Medicare beneficiaries spend $363 per person per month on Part B physician services alone. That is more than beneficiaries in Lincoln County, Montana spend on Part A and Part B combined!

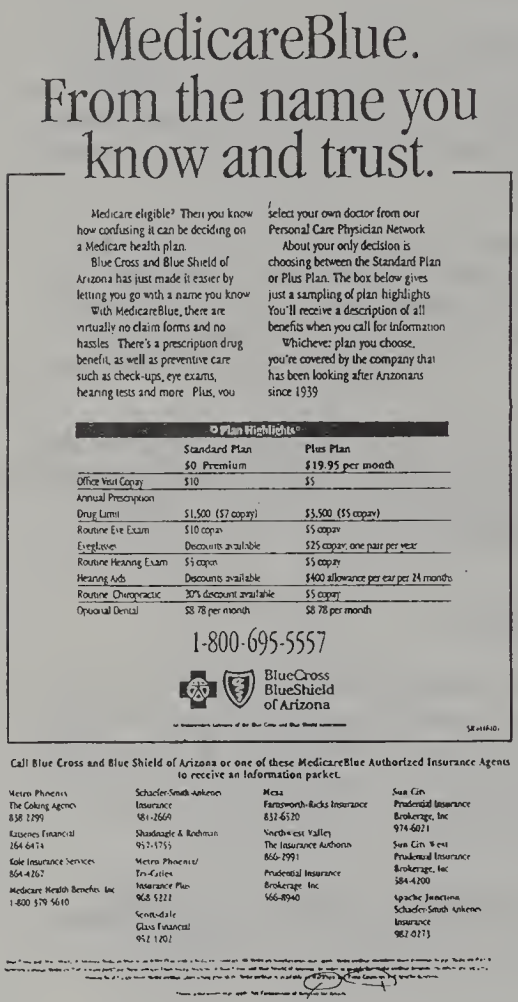
CONSEQUENCES OF PAYMENT INEQUITY

The consequences of the payment inequity are very serious for beneficiaries. Low spending in fee-for-service translates to capitated payment rates that are too low for an HMO [or other alternative] to bear the risk of the potential demand. As a result, large areas of the country have no HMO option and will not support alternatives such as PSOs if Congress decides to permit this model as well. Ten states have no HMO options, and there are many regions in other states with no choices.

The other serious consequences are the variation in benefits available in high spending areas. Pages ten and eleven provide a comparison of benefits available in

health plans across the country. The arithmetic is simple: the higher the payment, the richer the benefits. In some areas of the country, Medicare beneficiaries have choices of over ten HMOs, and these plans offer lavish drug benefits, dental care, hearing aids, low co-payments, no deductibles and other desirable options. But, beneficiaries in the states of Montana, Idaho, North Dakota, Wisconsin, for example, have no choices and no additional benefits. This is simply unfair.

A Sunday, November 3, 1996, advertisement from *The Arizona Republic* below illustrates how a benefit package looks in payment areas at the national average. The advertisement shows a very rich benefit package can be offered at the national average. What does that tell us about payments in other areas that are thousands of dollars more per year and growing?



MedicareBlue.
From the name you know and trust.

Medicare eligible? Then you know how confusing it can be deciding on a Medicare health plan.

Blue Cross and Blue Shield of Arizona has just made it easier by letting you go with a name you know.

With MedicareBlue, there are virtually no claim forms and no hassles. There's a prescription drug benefit, as well as preventive care such as check-ups, eye exams, hearing tests and more. Plus, you select your own doctor from our Personal Care Physician Network.

About your only decision is choosing between the Standard Plan or Plus Plan. The box below gives just a sampling of plan highlights. You'll receive a description of all benefits when you call for information.

Whichever plan you choose, you're covered by the company that has been looking after Arizonans since 1939.

Plan Highlights

	Standard Plan $0 Premium	Plus Plan $19.95 per month
Office Visit Copay	$10	$5
Annual Prescription Drug Limit	$1,500 ($7 copay)	$3,500 ($5 copay)
Routine Eye Exam	$10 copay	$5 copay
Eyeglasses	Discounts available	$25 copay, one pair per year
Routine Hearing Exam	$5 copay	$5 copay
Hearing Aids	Discounts available	$400 allowance per ear per 24 months
Routine Chiropractic	20% discount available	$5 copay
Optional Dental	$8.78 per month	$8.78 per month

1-800-695-5557

BlueCross BlueShield of Arizona

Call Blue Cross and Blue Shield of Arizona or one of these MedicareBlue Authorized Insurance Agents to receive an information packet.

Metro Phoenix
The Coking Agency
838-1299

Kaseney Financial
264-6474

Cole Insurance Services
864-4267

Medicare Health Benefits Inc
1-800-379-5610

Schaefer-Smith-Ankeney Insurance
581-2660

Shadeagle & Rechman
957-4755

Metro Phoenix/ Tri-Cities Insurance Plus
968-5221

Scottsdale
Glass Financial
951-1701

Mesa
Farnsworth-Rocks Insurance
832-6520

Northwest Valley
The Insurance Authority
866-1991

Prudential Insurance Brokerage Inc
966-8940

Sun City
Prudential Insurance Brokerage, Inc
974-6021

Sun City West
Prudential Insurance Brokerage, Inc
584-4200

Apache Junction
Schaefer-Smith-Ankeney Insurance
982-0273

This MedicareBlue HMO Plan providing additional benefits is available in Maricopa and Pima Counties, in the Phoenix, Arizona area with monthly payments of $489.67 and $464.24 respectively.

This clearly illustrates that plans offering additional benefits can be financed near the 1997 national monthly average of $467.

1997 Medicare HMO Benefits Comparison

Benefit	Honolulu, HI	Salem, OR	Eugene, OR	Seattle, WA	Sacramento, CA	Portland, OR	Los Angeles, CA	Orange County, CA	San Francisco, CA
Health Plan	Kapiolani Health Hawaii	Providence	SelectCare	Group Health	FHP	PacifiCare		Kaiser Permanente	
Product	Secure Care	Medicare Option	Senior Plus	Options Plan II	Health Plan for Seniors	Secure Horizons	Secure Horizons	Senior Advantage	Senior Advantage
AAPCC	$382.25	$321.05	$353.19	$409.54	$509.91	$388.56	$542.51	$572.69	$514.64
Premium	$70	$19.50	$38	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
MD Copay	$7	$10	$5	$5	$ 5	$7	$ 0	$ 3	$5
SNF Care	100 days	100 days	100 days	100 days	100 days	100 days	100 days	100 days	100 days
Eye Exam	$7	$10 copay	$5 copay	$5 copay	$ 5 copay	$7.00	$ 0 copay	$3 copay	$5 copay
Eye Glasses	Not Covered	$60 lenses, frames free every 2 years	$115 allowance every two years	lenses/ frame free allowance/2 years	$20 copay every 2 years	$20 copay for select glasses/2 years	$20 copay every 2 years	$60 frame allowance $ 0 lenses/2 years	$35 frame, $48 lense allowance/2 years
Hearing Exam	$7	$10 copay	$5 copay	$5 copay	$ 0 copay	Not Covered	$ 0 copay	$ 3 copay	$5 copay
Hearing Aids	Not Covered	Not Covered	Not Covered	$250 credit every 2 years	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Outpatient Pharmacy	$ 7 copay $ 500 annual cap	Not Covered	Not Covered	Not Covered	$ 5 copay $1,600 annual cap	Not Covered	$ 7 copay no annual cap	$ 7 copay no annual cap	$7 copay $1,600 annual cap
Dental	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	$ 5 copay basic coverage	$ 5 copay basic coverage	Not Covered

1997 Medicare HMO Benefits Comparison

Benefit	Phoenix, AZ	Miami, FL	San Diego, CA	Denver, CO	Philadelphia, PA	New York, NY	Pittsburgh, PA	Boston, MA
Health Plan	CIGNA	Humana	FHP		Blue Cross/Shield	Oxford	US Healthcare	Harvard/ Pilgrim
Product	Healthcare for Seniors	Medicare Plan	Senior Plan	Senior Plan	Keystone 65	Medicare Advantage	Medicare 5 Plan	First Seniority
AAPCC	$491.27	$669.30	$517.20	$450.07	$579.59	$714.58	$553.24	$539.64
Premium	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
MD Copay	$ 5	$ 0	$ 0	$ 5	$ 5	$ 10	$ 5	$ 5
SNF Care	100 days	100 days	100 days	100 days	100 days	100 days	100 days	100 days
Eye Exam	$ 5 copay	$ 0 copay	$ 5 copay	$ 5 copay	$ 0 copay	$ 0 copay	$ 5 copay	$ 5 copay
Eye Glasses	$50 allowance per year	$150 allowance every year	$20 copay every 2 years	$125 allowance every 2 years	$ 100 allowance every 2 years	Free every 2 years	$ 70 allowance every 2 years	$ 100 allowance every 2 years
Hearing Exam	$ 5 copay	$ 0 copay	$ 0 copay	$ 5 copay	$ 5 copay	$ 0 copay	$ 5 copay	$ 5 copay
Hearing Aids	$ 100 allowance every 2 years	$700 allowance every 3 years	Not Covered	Not Covered	$ 500 allowance every 3 years	$ 500 allowance every 3 years	$ 500 allowance every 3 years	$ 500 allowance every 4 years
Outpatient Pharmacy	$ 7 copay $2,000 annual cap	$ 0 copay No annual cap	$ 6 copay $3,500 annual cap	$ 5 copay $1,500 annual cap	$ 5 copay $1,500 annual cap	$ 7 copay $1,000 annual cap	$ 10 copay $1,500 annual cap	Not covered
Dental	Not Covered	$ 0 copay basic coverage	$ 5 copay basic coverage	$ 5 copay basic coverage	$10 copay basic coverage	$ 0 copay basic coverage	$ 2 copay basic coverage	80/20 indemnity basic coverage

Prepared by the OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS
a member of *The Coalition for Fairness in Medicare*

WHAT ARE THE SOLUTIONS

There are three key changes necessary to address the fundamental inequity in a manner that preserves the fiscal integrity of the program, increases choices for all, and opens the door to greater equity for all beneficiaries.

▷ DECOUPLE THE CAPITATED PREMIUM PAYMENT FROM TRADITIONAL MEDICARE

It is clear that basing Medicare capitated premium payments on open-ended bill paying of doctors and hospitals makes no sense. It significantly overpays in some areas and underpays in others. Rural underserved areas are deprived of choices. Efficient market areas like Portland, Oregon and Des Moines, Iowa are penalized for conservative practice patterns.

The most important step is to break the link between the two sides of the program. However, the challenge is how to get from the current severely unlevel playing field to rational prospective payment for Medicare premiums. We cannot begin the process unless we delink the payments. To keep balance between the two programs, however, the inflation factor in the managed care side of the program should be consistent with fee-for-service inflation increases. Ultimately, risk contract payments should move toward market-based competitive bidding after geographic equity has been achieved.

▷ "NORMALIZE" THE VARIATION THROUGH RATE BLENDING

During the 1995 Balanced Budget debates, the Senate developed and passed a blending formula designed to reduce the variation between the high and low counties. This blend was included in the 1995 Balanced Budget Act, and has reappeared in the President's 1998 Budget Proposal and a number of the bills that have been introduced by members of this Committee.

A similar methodology was used to normalize the rate variation among hospital and physician payments in the early days of the Medicare program. In the 1960s and 1970s, Medicare paid providers based on "reasonable and customary" charges. There was wide variation among these customary charges for the same services based on historic patterns.

Over the course of a ten year period, HCFA created a blending formula that moved the higher charges gradually downward and the lower charges gradually upward toward a national average. Now the Diagnosis-Related Groups [DRGs] in Part A and the Resource-Based Relative Value Scale [RBRVS] formula for Part B vary only by input price adjustments that reflect well-documented differences in prices in various counties.

A blending formula can serve the same purpose for the capitated payment variation in the AAPCC. The mechanisms is to blend, in increasing proportion, the local payment rates with a national input-price adjusted average payment [a variation of the USPCC]. Over time, the higher payment counties grow more slowly and the lower counties rise faster than the national average. The blending concept is illustrated by the hypothetical formula below:

National Average	County A Monthly Payment	County B Monthly Payment
$500	$600	$400

If the blending rate was 60% local and 40% national, the result of a blend would be:

	County A		County B	
60% of the "Local" Payment	$ 600 x .60 =	$ 360	$ 400 x .60 =	$ 240
	+		+	
40% of the National Average	$ 500 x .40 =	$ 200	$ 500 x .40 =	$ 200
		$ 560		$ 440
	County A is reduced by $40		County B is increased by $40	

The issue becomes simply how fast do you blend the rates and how far do you want to move to a national norm. Given the information we have regarding the premiums paid in FEHBP, the legitimate variation should be quite small. Various bills introduced in this Congress use a variety of graduated formulas. The Fairness Coalition supports a move toward at least a 50/50 blend over five years. If the increases come from the future allowable growth, it is possible to accomplish a major reduction in variation without significantly disrupting current market rates. However, there is no precedent for "holding harmless" any areas from the effects of necessary reforms to achieve beneficiary equity and choice.

▷ Payment Floors

The purpose of a payment floor is to insure that premium based options will be available in all markets within a reasonable period of time after the reforms are enacted. For areas that are far below the national average, only a major increase will ensure that these primarily rural areas, will have a chance to participate in the new modern Medicare program.

The 1995 Balanced Budget Act included a payment floor for 1997 of $350. The President's Proposal includes a floor of about $350 for 1998. Many of the bills recently introduced express the minimum payment in terms of a percentage of the average – 80

or 85 percent are currently in play. The Fairness Coalition recognizes the importance of rectifying the inequity and offering options to beneficiaries as soon as possible. We support a payment floor of 85 percent of the national input price adjusted average.

We have developed information on costs of offering a Medicare risk contract in low spending areas. *"What it Takes to be A Risk Contractor,"* found on pages fifteen and sixteen include actual data from health plans trying to offer a premium based product. We believe the experience of current risk contractors and that of health plans trying to assess whether to enter new markets justify a payment floor of 85 percent of the average. However, we are aware that a rapid blending formula may obviate the need for payment floors as the low counties would rise rapidly with an aggressive blend. Whatever the method, the result should be that all beneficiaries should have the option of choosing a private sector, premium-based option as soon as possible. All providers should have the opportunity to participate in an alternative as well.

▷ All Payment Reforms Should Enhance Equity

There are a number of other proposals to alter the payment methodology that will be addressed by others at this hearing, or will be addressed in other forums. These include changes in the way we finance Graduate Medical Education [GME], Disproportionate Share Hospital [DSH] payments, and risk selection adjustments. The Fairness Coalition believes that all other changes should be analyzed to ensure that the results of these other proposals do not set back the goal of equity and fairness. Some solutions such as across-the-board rollbacks in percentage payment [the so-called 95 to 90 percent reduction] will unfairly penalize low payment areas trying desperately to get into the game. Risk adjustment tools should be prospective and broad-based. Across-the-board cuts on an unlevel playing field exacerbate the problem of risk skimming and will keep choices from being offered in many markets.

Reform of GME funding is an important fairness and equity issue and a defined funding mechanism needs to be identified to insure the appropriate training of future practitioners. GME reform should be sequenced with AAPCC payment reform efforts which will decrease geographic inequities that prevent choices in all markets.

CONCLUSION

Congress has an opportunity to assure fiscal solvency of the Medicare program in the short term. The Coalition for Fairness in Medicare believes reform can also offer more choices in a competitive environment and do so within the budgetary constraints of the budget agreement. The Coalition believes that a transition can be devised to move Medicare in the right direction. I thank you for giving us this time to offer our views, and will be pleased to answer any questions that you may have.

What It Takes to be a Medicare Risk Contractor

With the enactment of the Tax Equity and Financial Responsibility Act of 1982 [TEFRA 82], Congress authorized a Health Maintenance Organization [HMO] option to Medicare beneficiaries as an alternative to traditional fee-for-service [FFS] Medicare. In FFS, Medicare pays claims of hospitals and physicians for covered benefits. By way of contrast, an HMO is paid a monthly premium for each enrolled beneficiary. The agreement is called a "risk contract" because the HMO, like an insurer, assumes the financial risk of providing all covered services.

Like any insurer, a risk contractor must carefully evaluate whether the monthly premium is sufficient. Below is a simplified explanation of the process of calculation:

1] What it costs an HMO to offer a risk plan to Medicare Beneficiaries:

- *Base Rate* - An HMO calculates the rate it charges to commercial [non-Medicare] enrollees for health benefits.
- *Initial Rate* - Is the amount an HMO would charge commercial [non-Medicare] enrollees for the services covered by Medicare [base rate less adjustments].
- *Adjusted Community Rate [ACR]* - An HMO multiplies the initial rate by utilization factors for the Medicare program. In general, Medicare beneficiaries use 3.5 to 4 times more health care resources than the younger, commercial population.

2] The monthly Medicare contribution to an HMO per enrollee:

- *Adjusted average per capita cost [AAPCC]* - the amount of health care services Medicare beneficiaries use in a specific county. There is wide variation in the AAPCC depending primarily on differences in intensity of use of services.
- *Average Payment Rate [APR]* - Medicare then makes adjustments to the AAPCC for specific health plans based on the demographics of a plan's anticipated enrollment [age, gender, institutional status]. As a rule of thumb, the APR is on average about 80-85 percent of the AAPCC as a result of demographic adjustments.

3] Plan Costs [ACR] v. Medicare Payments [APR]:

To determine the financial viability of entering into a risk contract, a health plan compares the ACR [the cost of offering a Medicare risk plan] with the APR [the amount Medicare will pay]. Two options emerge:

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- If the APR is greater than the ACR, the HMO is more likely to offer a plan. The plan can "spend" the difference in the form of extra benefits, such as prescription drugs, eye glasses, hearing aids or reduce/eliminate enrollee premiums and copayments, reduce the monthly [APR] payment from HCFA [never done], or contribute to a Benefit Stabilization Fund [BSF].

- If the APR is less than the ACR, the plan may decide not to enter the market. It can, however, charge an additional premium [over and above the Part B premium] to make up the difference. If that premium is too high, the plan will not able to attract enrollment. In areas where the AAPCC is very low, the economics are a clear deterrent to market entry.

Examples of How the Calculation Works

Payment rates are crucial to determining how well the HMO option will fare in any given county. Below are two examples of plan calculations in counties with payments below the national average of $467. The figures below are based on 1997 data provided by plans doing business in the designated communities. The AAPCC is just the starting point. The real issue is costs [ACR] versus revenue [APR + beneficiary premiums] in each county.

	Jackson County, OR [Unadjusted AAPCC = $304]		Salt Lake County, Utah [Unadjusted AAPCC = $366]		Hennepin County, MN [Unadjusted AAPCC = $405]	
Total Plan Costs [ACR]		$375		N/A[1]		$452
Total Plan Revenue		$308		$321 - $381		$418
Adjusted AAPCC [APR]	$308		$307		$345	
Beneficiary Premium	$ 35		$14 - $74		$73	
Monthly Gain/Loss		[$ 67]		N/A[1]		[$34]

[1] This plan has been operating for less than one year. Data is not available, however actuaries anticipate significant losses.

What Does this Mean?

The ACR process has been criticized and is not a perfect model for determining plan costs. However, the numbers are undeniable. While there may be other barriers to HMO entry, the payment rate is a critically important factor.

Low payment rates will deter plans from offering a Medicare risk product. This is true even if the FFS spending is substantially below a proposed Medicare premium [i.e., if an AAPCC floor is instituted]. Plans bear the risk of increased demand, must provide all services covered by FFS Medicare, and ensure access to specialty care. Pent up demand, particularly in rural areas, can be anticipated.

If HMO [and PPO] choices are to thrive in all markets, an adequate and equitable payment is essential.

The CHAIRMAN. Thank you, Ms. Foote. Dr. Colby.

STATEMENT OF DAVID COLBY, PH.D., DEPUTY DIRECTOR, PHYSICIAN PAYMENT REVIEW COMMISSION, WASHINGTON, DC

Mr. COLBY. I am pleased to be here today to talk about the views of the Physician Payment Review Commission. My remarks will focus on risk selection and risk adjustment issues. I want to talk about the problem, why we care about this problem, and the solutions. The written testimony contains information about improving managed care payment policy in general, and also some issues about improving equity in payments under fee-for-service.

Differences in the AAPCC are really due to two things. One is the payment policy and the other is volume of services delivered. Congress previously has made payment policy decisions which account for some of the differences across payment areas such as payment policies for graduate medical education, disproportionate share, and the input prices on the physician and hospital side. The other part that drives this is the volume of services, and that is driven, as Susan said in her testimony, by practice patterns, but it is also driven by differences in health status across the country, and that is very important to what I am going to say today.

What is the problem of risk selection in Medicare managed care? The basic problem is that those beneficiaries in managed care are healthier and therefore HCFA overpays HMOs and a second problem is that some plans serve sicker beneficiaries and other plans serve healthier beneficiaries. If you look at what is Figure 8, which is the second to last figure in the testimony, you will see that for new HMO enrollees their costs prior going into managed care are considerably below those who stay in fee-for-service. That is they are 63 percent of those who stay in fee-for-service. Those who leave managed care, which is a very small number, are considerably more expensive than those who stayed in fee-for-service.

The research literature supports this. The research literature is done over different time periods, and it is done with different methodologies. It consistently shows that Medicare managed care beneficiaries are more healthy than those in fee-for-service. It also shows over time that Medicare beneficiaries who are in managed care regress towards the mean. That is they start to look like Medicare fee-for-service beneficiaries over a time period, but initially they are a lot healthier.

I would like to now switch to the second problem which is demonstrated on Figure 9 on the last page of testimony. Some plans get healthier beneficiaries and some plans get sicker beneficiaries. If you look at the contrast between Plan B and Plan D, Plan B receives a higher proportion of beneficiaries who are new enrollees, and Plan D keeps enrollees over a longer time period. We presume that one plan is getting healthier beneficiaries and one is getting sicker beneficiaries.

Why should we care about these problems? Well, the first reason to care about the problem is the budget. We are overpaying managed care plans because they are getting healthier beneficiaries. The second reason, and one that is not talked about as much, is a market reason. That is we would like plans to survive because

they are efficient and treat beneficiaries appropriately, not because they serve the healthiest beneficiaries. That is we do not want to have windfall gains and windfall losses. We want to be able to pay appropriately given the characteristics of beneficiaries. The third reason that we care about this problem is we care about it for vulnerable populations. We want vulnerable populations to have as many choices as other Medicare beneficiaries have. That is we want to pay plans fairly so vulnerable populations are attractive to them.

What can we do about it? We can do some short-term things. Among the short-term things, we could pay managed care plans less for new enrollees because they are healthier and we could also adjust county rates, that is the AAPCC rates, for the differences in health status across the United States. By doing the latter you would raise payments in rural counties and you would lower payments in urban counties. In the longer-term, we need to better develop our methods for risk adjustment, and most importantly, we need to have data reporting requirements. We need to get information from health plans about the health status of beneficiaries in them.

In conclusion, let me say one thing which is not about payment policy but is very important when you are thinking about these changes. The effects of these payment changes that we are talking about are uncertain. The Commission recommends that HCFA be required to monitor access in a timely fashion in both fee-for-service and managed care as these changes take place. Thank you very much.

[The prepared statement of Mr. Colby follows:]

Physician Payment Review Commission

STATEMENT BEFORE

Special Committee on Aging U.S. Senate

on

Medicare HMO Payment Policy

May 19, 1997

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David C. Colby, Ph.D.
Deputy Director

Mr. Chairman and members of the Aging Committee, I am pleased to be here today to discuss increasing choices and equity in the Medicare program. The Physician Payment Review Commission has substantial expertise in this area, beginning with our work on physician payment reform in the late 1980s and continuing into our more recent work concerning Medicare's managed-care program.

Throughout our work, we have looked for ways the program can benefit from the tremendous changes that are occurring in how Americans pay for and receive health care. The number of individuals covered by traditional indemnity insurance is shrinking. Managed-care plans are evolving toward more integrated systems and closer relationships with their provider networks, while physicians and hospitals are joining together in new types of organizations. In response to rising premiums, leading corporate purchasers of health care are changing the way they pay for health services, potentially affecting both the costs and quality of care.

Medicare can learn from these experiences. In fact, as commercial managed-care penetration grows and managed-care enrollees reach retirement age, it is inevitable that more and more beneficiaries will select this option within Medicare. Moreover, changes can be made in the traditional program that can help contain costs and improve quality. The challenge is to develop reforms that ensure both Medicare's financial solvency and beneficiary access to timely, appropriate health care services.

Expansion of managed care and introduction of new private health plan options for Medicare beneficiaries present both opportunities and challenges. It is important to keep in mind, however,

that Medicare differs from other payers in several important ways. First, Medicare managed-care enrollment, while growing, still lags substantially behind commercial enrollment (Figure 1). Second, although managed-care growth in the private sector has been associated with reduced cost growth, under current policy, this is not the case for Medicare. In fact, research studies suggest that managed-care growth *increases* program outlays. Third, the private market encompasses a broader range of plan options than Medicare currently permits, but most individuals with employer-based insurance have only a limited number of plans from which to choose. Fourth, as a public program, Medicare may face certain obstacles in quickly adopting and implementing techniques for managing care that have been used by other payers.

In developing a work plan, conducting analyses, and discussing policy alternatives, the Commission has been working closely with congressional committees and staff to ensure that we can help inform your deliberations. My comments today begin with some brief background information about Medicare managed care and the issues that will arise as managed-care choices expand. Then I would like to highlight several topics that are most immediate on the congressional agenda:

- improving payment policy under Medicare's managed-care program,
- addressing the critical issue of risk adjustment, and
- improving equity of payment policy under Medicare fee for service.

MEDICARE MANAGED CARE: PLAN PARTICIPATION AND BENEFICIARY ENROLLMENT

As you know, Medicare managed care is growing. By the end of 1996, about 13 percent of Medicare beneficiaries were enrolled in some form of managed care, compared to 5 percent in 1990. Participation by beneficiaries varies widely, with over 20 percent of urban beneficiaries enrolled in managed care, compared to about 1 percent of rural beneficiaries. Although predominantly an urban phenomenon, enrollment rates differ across urban areas. Over half of beneficiaries in Riverside, CA, are in risk plans, for example, while virtually none are enrolled in risk plans in Atlanta and Detroit (Figure 2).

Most plans participate in Medicare through the risk-contracting program. Under a risk contract, plans commit to providing Medicare-covered services to beneficiaries for a fixed monthly payment from the program. There were 241 risk contracts in effect at the end of 1996; 35 more had been added as of April 1st (Figure 3).

Current policy allows only health maintenance organizations (HMOs) to be offered to Medicare beneficiaries (some of which offer point-of-service coverage). The Health Care Financing Administration's (HCFA) Medicare Choices demonstration, however, is testing the development of other types of managed-care products, such as preferred provider organizations and provider-sponsored organizations.

The availability of risk plans varies widely across the nation. In most urban areas, beneficiaries can choose among several plans, while 80 percent of rural beneficiaries have no plan available. Overall, about two-thirds of beneficiaries are served by at least one risk plan; 50 percent have access to more than one plan (Figure 4).

IMPROVING MEDICARE MANAGED-CARE PAYMENT POLICY

The debate on Medicare managed care always eventually turns to payment. Changes in payment policy could serve any of several goals: reducing program spending, encouraging managed-care enrollment by making the program more attractive to plans in certain markets, improving equity by reducing the variation in benefits offered by risk-plans in different areas of the country, or structuring payment policies so that the government remains neutral about the health plan choices beneficiaries make. The challenge facing policymakers is to develop an approach to paying plans that is fair, reduces cost growth, and ensures that beneficiaries have access to appropriate care at a cost they can afford.

As you have heard, there are a number of problems associated with Medicare's current payment methods. I will focus on the options for addressing these problems (including those included in the Balanced Budget Act passed in the last Congress and the President's February budget proposal) as well the Commission's recommendations concerning their implementation.

Current Policy Affecting Risk-Plan Payment, Benefits and Premiums

As a result of current policies and local competitive pressures, there is wide geographic variation in Medicare payments to risk-plans, in the benefits available to beneficiaries, and in the premiums that they pay. For example, there is a three-fold difference between the lowest and highest county payment rates (Figure 5). Over 50 percent of 1997 county rates, however, are between $340 and $440. Currently, more than three-quarters of risk plans offer additional eye and ear care, and over half provide prescription drug coverage (Figure 6). By the end of 1996, two-thirds of plans provided benefits beyond those covered by Medicare at no additional charge to enrollees (Figure 7).

Payments, benefits, and premiums are the result of two separate administrative processes, as well as of local competitive pressures. Payments are set to reflect local fee-for-service costs with some adjustment for differences in the demographic characteristics of local populations that affect their use of health services. This measure, known as the AAPCC, is the expected local cost of caring for a typical beneficiary. Each county's payment is set at 95 percent of the AAPCC. Plans are paid this rate with an adjustment for enrollee characteristics.

Benefits and premiums are set in a second process in which plans submit their estimated cost of providing Medicare-covered services to enrollees based on the costs of serving their commercial population. If these costs fall below the Medicare capitation payment, then the plan must return the difference to Medicare or to beneficiaries in the form of additional benefits. In practice, all plans

opt to provide additional benefits to beneficiaries. In addition, to be competitive, plans may also offer even more benefits than those required under this process.

Concerns about Current Policy

The wide geographic variation and volatility in spending for traditional Medicare results in large differences in the AAPCC across counties. These differences may contribute to the uneven pattern of Medicare managed-care enrollment that I described earlier. And they account, at least in part, for the wide and seemingly arbitrary variation in additional benefits that Medicare beneficiaries receive from risk plans in different markets.

Several factors that could be addressed in legislation contribute to this geographic variation. The most important of these are:

- **Inadequacies of current demographic risk adjusters.** Inadequate risk adjustment results in increased Medicare spending in two distinct ways. First, local rates may overstate the likely cost of a typical beneficiary because the AAPCC reflects only beneficiaries in fee-for-service. If these beneficiaries are less healthy than those in managed care and their poorer health is not captured by the current demographic adjusters, then expected fee-for-service payments are overstated. In fact, the Commission's analysis shows that new managed-care enrollees have significantly lower health care costs than those who remain in fee for service (Figure 8).

Second, in addition to the local rate being biased, inadequate risk adjustment results in overpayments to plans for their particular enrollees. Risk adjusters currently used in the Medicare program explain only a small portion of the variation in health costs among Medicare beneficiaries. More accurate risk adjustment would result in lower payments to plans reflecting their relatively healthier enrollment. Commission analyses of new enrollees suggest that currently available risk-adjustment methods would capture at least half of the true risk selection in Medicare managed-care plans.

As I will explain in a moment, the Commission made a series of recommendations concerning risk adjustment in its 1997 annual report to the Congress. Better risk adjusters would make the AAPCC a more accurate reflection of expected outlays for a typical beneficiary and would reduce some of the variation in payments.

Inclusion of earmarked funds. Medicare makes payments to hospitals for graduate medical education and for serving a disproportionate share (DSH) of low-income patients. Including these special funds in AAPCC-based rates contributes to geographic variation in managed-care payments. It also raises the question of whether these payments should be passed along to all risk-plans, since they are meant to compensate hospitals for special circumstances beyond the costs of caring for Medicare patients.

The Commission has recommended that these funds be removed from the AAPCC. A related issue is whether teaching and DSH hospitals should receive additional compensation

for seeing managed-care enrollees or whether managed-care plans should be compensated an additional amount for teaching or serving low-income patients. The Commission recommends that mechanisms be developed to ensure that hospitals, plans, and other entities involved in training are paid fairly for these costs.

- **Geographic basis of rates**. Use of counties, which are relatively small geographic units, in setting payments leads to more variation and volatility than may be appropriate. Variation and volatility reflect differences in practice patterns, differences in the health status of local populations, and, at least in some cases, small numbers of beneficiaries. Areas larger than counties would help address these problems and may be more consistent with the notion that managed-care plans serve markets, not counties. Using larger areas, however, obscures information about the variation in health status at the county level that contributes to the accuracy of payment. For this reason, any changes to geographic areas should be accompanied by implementation of better risk adjusters.

It is important to recognize that even if all of these technical issues were resolved, under current policy, savings from managed-care enrollment cannot exceed 5 percent. Because managed-care payments increase in lock-step with Medicare fee-for-service expenditures, cost increases in fee for service drive cost increases throughout the program. To expand managed-care without increasing outlays may require breaking the link between managed-care payments and fee-for-service expenditures.

Proposals for Change

Over the past two years, the Congress and the Administration have been considering how to set Medicare capitated rates that are fair to plans and allow the program to benefit from managed-care efficiencies. Proposals to improve risk-plan payment policies were included in the Balanced Budget Act passed during the 104th Congress. Proposals supported by the Administration last year and more recently put forward in the President's fiscal year 1998 budget proposal have many similarities. All of these proposals included provisions previously recommended by the Commission.

There are basically three different ways to reduce the variation in risk-plan payment rates. These approaches could be implemented to achieve budget savings, or could be budget-neutral, focused solely on reallocating payments across areas.

The first approach is to improve the AAPCC. Improving risk adjustment, removing earmarked funds, and changing the geographic basis of the local rate would all result in better estimates of patient care costs, which would differ less across areas. All of these modifications are among the changes the Commission recommended in this year's annual report. It also recommends that, once graduate medical education costs are removed from the AAPCC, separate mechanisms should be developed to ensure that hospitals, managed-care organizations, and other training entities are paid fairly for those costs when they are involved in appropriate training activities. The General Accounting Office has recommended that the experience of managed-care enrollees be used in

addition to those in fee for service in calculating county rates. This would result in county rates reflecting the costs of all Medicare beneficiaries.

A second approach is to unlink risk payments from local spending, using current rates as a starting point for new rates. A variety of strategies could be used to set rates which have less geographic variation than those now based on the AAPCC. These include blending current local rates with national rates, trimming rates through floors and ceilings, and setting new ways to update local rates. Since these approaches begin with the AAPCC, the Commission recommends that if they are adopted, that they be adopted in tandem with the improvements in the AAPCC that I just mentioned.

Finally, current policy could be discarded altogether in favor of market-driven competitive solutions. Local market characteristics could be used to set rates, either through some form of competitive bidding or a defined federal contribution for both fee-for-service and risk beneficiaries. This approach would work only in markets with sufficient local competition. It could be adapted to markets with little managed-care penetration if payments are based on the cost experience of both managed-care and fee-for-service beneficiaries. The Commission has recommended that HCFA continue to test such alternative methods for setting payments, including competitive bidding, partial capitation, and reinsurance.

THE IMPORTANCE OF RISK ADJUSTMENT

Regardless of how payment rates are set, as long as Medicare beneficiaries can choose among options, improved risk adjustment will be essential. Otherwise, plans will not be fairly paid for enrollees with better or worse-than-average health status (for example, those with chronic conditions or functional disabilities). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for.

In addition, lack of risk adjustment translates into higher costs to Medicare. The Commission estimates that annual excess payments to health plans total $2 billion. A recent study by the General Accounting Office similarly found that, in 1995, Medicare overpaid $1 billion to plans in California. Improved risk adjustment would have reduced the excess by about $276 million.

The Commission recommends that improved risk adjustment be implemented immediately. Although available approaches are not perfect, they would do a better job than the demographic factors currently used. As a first step, the Commission recommends that Medicare begin to phase-in risk-adjusted payment changes using administrative data. For example, our analyses and those of others would support an approach of paying less for new managed-care enrollees who have lower-than-average per capita costs. (New enrollees now account for 55 percent of Medicare managed-care enrollees, up from 43 percent in 1993.) Since risk adjustment methods typically underpredict the true variation in costs and selection, improvements such as paying less for new enrollees do not risk over adjusting (that is paying too little) for individuals with certain characteristics.

Because there are substantial differences among plans in the proportion of new enrollees, this approach would be preferable to an across-the-board cut which would particularly hurt those plans with a large proportion of long-time enrollees (Figure 9). The President's budget proposes such a cut, setting local rates at 90 percent of the AAPCC, instead of the 95 percent under current policy. Although this would mitigate the budget impact of risk selection against the fee for service program, it would not adjust for risk selection among managed-care plans and so would not reduce plans' incentives to avoid enrolling costly beneficiaries.

Steps could also be taken immediately to improve the availability of data useful for risk adjustment. For example, hospitals are now required to submit so-called no-pay bills to HCFA for hospitalized managed-care enrollees but many do not do so. The potential use of these data for risk adjustment increases the importance of enforcing this requirement.

Use of administrative data for risk adjustment is an important first step. Over the longer term, however, the data and infrastructure required to support risk adjustment should be developed and implemented. This includes obtaining data that more accurately capture risk (such as those obtained from surveys of beneficiaries or encounter data collected by plans and their contracting providers), further development of risk adjustment models, and implementation of adjusted payment rates.

EFFECTS OF CHANGES IN MANAGED-CARE PAYMENT POLICY

The effect of any payment changes on total Medicare payments, plans, and beneficiaries will ultimately depend upon how they are implemented, how much payment levels change, and how plans and beneficiaries respond. The effect of payment floors, blended rates, and other approaches to reducing inappropriate variation in risk plan payments will differ, depending upon the exact combination of policies and the sequence in which they are calculated.

The effects of changes on plan participation and beneficiary enrollment are also uncertain. If plans and beneficiaries are sensitive to payment rates, then rate changes could lead to participation increases in areas with increased rates and declines in those where rates drop. But if plans and beneficiaries are relatively insensitive to risk-plan payment rates, then we might not see such effects.

Unfortunately, there is little information that could guide us in predicting how plans and beneficiaries will react to payment changes. Researchers have been examining this question but their conclusions have been mixed. One recent analysis indicated that plan entry into the risk program is highly sensitive to the local payment rate. Another published study found that beneficiary enrollment rates are much more sensitive to factors such as local managed-care penetration in the commercial market than to local Medicare rates.

If risk payments differ from per capita fee-for-service outlays, then more detailed information about beneficiaries' enrollment behavior will be required in order to make accurate budget projections. In

particular, it will be important to understand how beneficiaries of different risk categories select between managed care and fee for service. The Commission has concluded that any changes in payment policy should be designed and phased in so as to reduce disruptive effects on beneficiaries and plans. Policymakers must also be mindful about the impact of changes in risk-plan payments on local markets where risk plans compete not only against each other but against Medicare fee for service. Efforts will also be needed to monitor the impact of any changes on beneficiaries' access to care.

Finally, it is critical to remember that expansion of Medicare managed care raises issues beyond setting payments to plans. The Commission this year is reiterating recommendations with regard to the process through which beneficiaries learn about their choices, enrollment and disenrollment policies, and enrollee grievance procedures. These recommendations were described more fully in its *Annual Report to Congress 1996*.

EQUITY IN MEDICARE FEE FOR SERVICE

Since the Commission began its work to reform Medicare's method for paying physicians, improving equity in payment has always been an important goal. My comments this afternoon focus primarily on physician payment because of the Commission's expertise in this area. While some of the same issues arise under other service sectors (for example, inpatient hospital, skilled nursing facilities, outpatient hospital), it is important to note that differences in current payment methodologies may dictate different types of policy solutions.

It is also important to keep in mind that managed-care payments are made for a bundle of services (reflecting both the price and volume of those services). Thus, variation in managed-care payments reflects variation in expenditures. Fee-for-service payments, in contrast, reflect only price. For the most part, there are deliberate policies designed to constrain geographic variation in price to an appropriate level.

With respect to physician payment, use of geographic adjustment factors serve the purpose of limiting variation in price to variations in the resource costs needed to provide particular services. Geographic adjustment factors were established for implementation of the Medicare Fee Schedule beginning in 1992. HFCA adopted a new method to define fee schedule payment areas last year. In addition, processes are in place to periodically modify both the geographic adjustment factors and payment area definitions, and the Commission has judged these to be generally successful in addressing outstanding problems. Committee staff have brought to our attention their concerns about the hospital wage index. Our sister commission, the Prospective Payment Assessment Commission, has identified issues in the calculation and application of the index and has recommended improvement. It should be a good resource to the Committee in developing options to promote equity in Medicare payments to hospitals.

Geographic variation also reflects differences in volume, which has been a challenge to control for both Medicare and private payers. This is because there are two sources of geographic variation in volume: discretionary sources (such as provider practice styles) and nondiscretionary ones (for example, health status). It is generally agreed that providers should not be held accountable for

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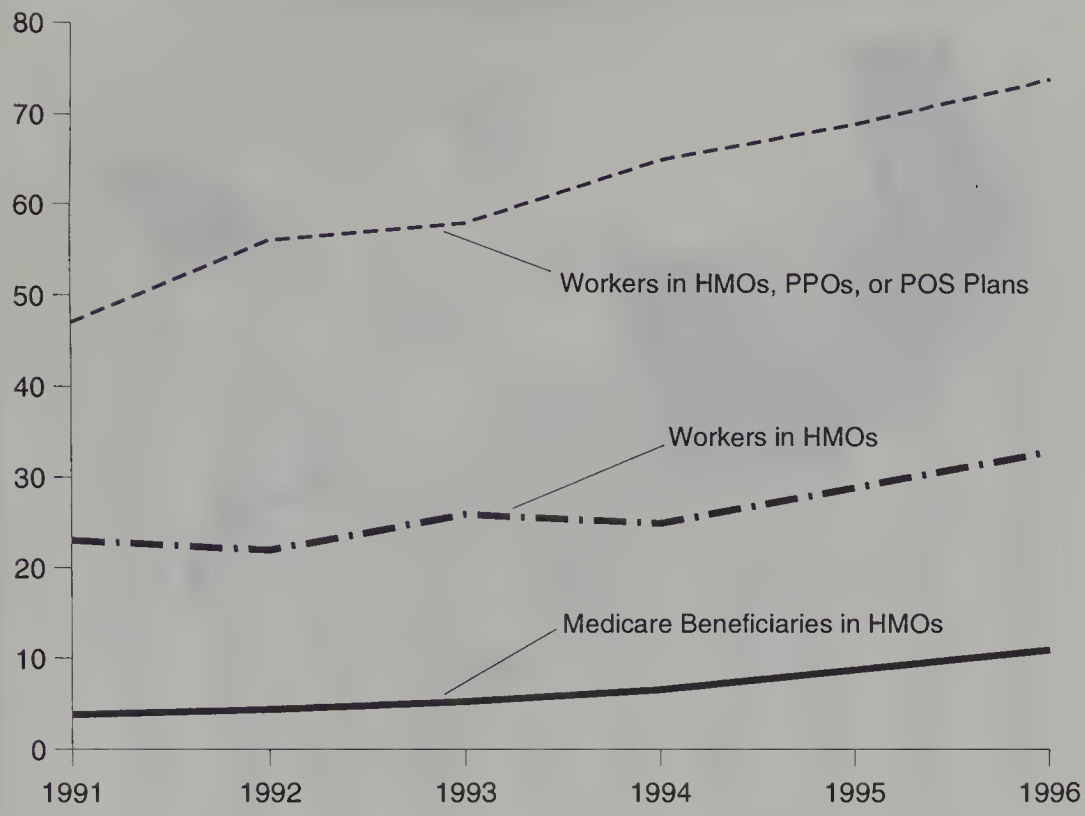
variation in service use due to factors like health status, but that reduction of differences in practice patterns is desirable. Policy tools that distinguish among the sources of variation are not well developed, although both profiling of providers and development and dissemination of practice guidelines have potential and should be encouraged.

After the Volume Performance Standard (VPS) system (under which growth in volume affects the price Medicare pays to physicians) was implemented in 1990, the Commission considered the feasibility of moving to a state or substate-level VPS system. Among other potential advantages, such a system could place greater pressure to control volume on physicians in areas with high rates of expenditures per beneficiary. Because of significant problems in establishing appropriate subnational spending targets and fee updates, as well as the year-to-year volatility of expenditures at the subnational level, the Commission concluded that the limitations of this approach exceeded its benefits.

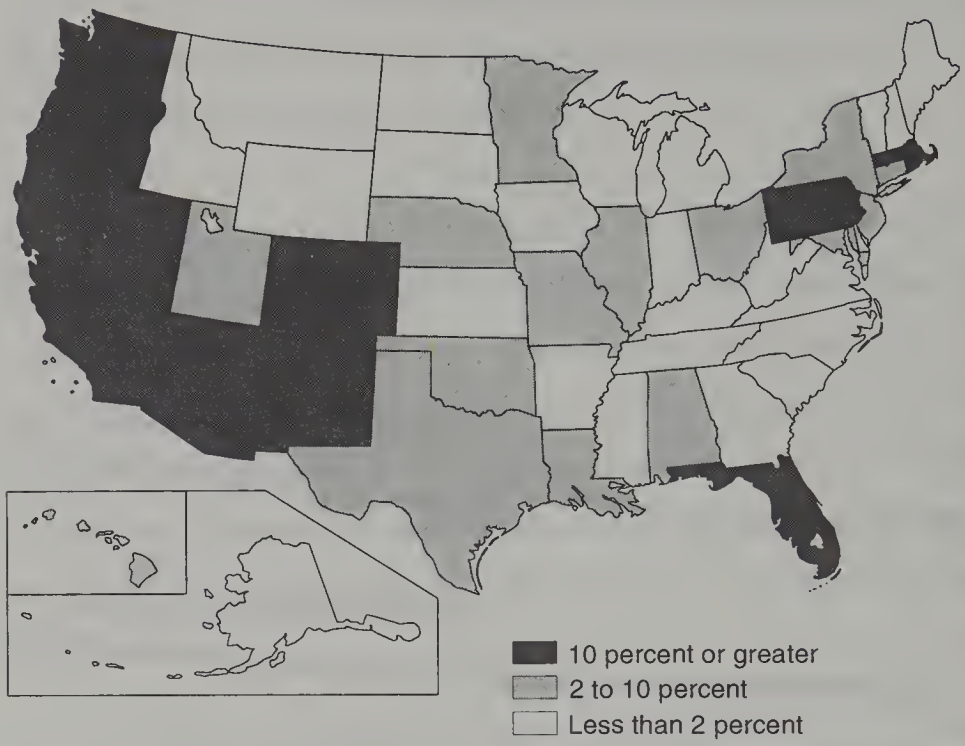
As Congress considers broadening the choices available to Medicare beneficiaries (and assuming that the traditional program remains a choice), it will be increasingly important to address how to constrain volume and reduce inequities across geographic areas. The Commission plans to continue working in this area and we will keep you and your staff informed of our progress.

Figure 1. Trends in Managed-care Enrollment, 1991-1996



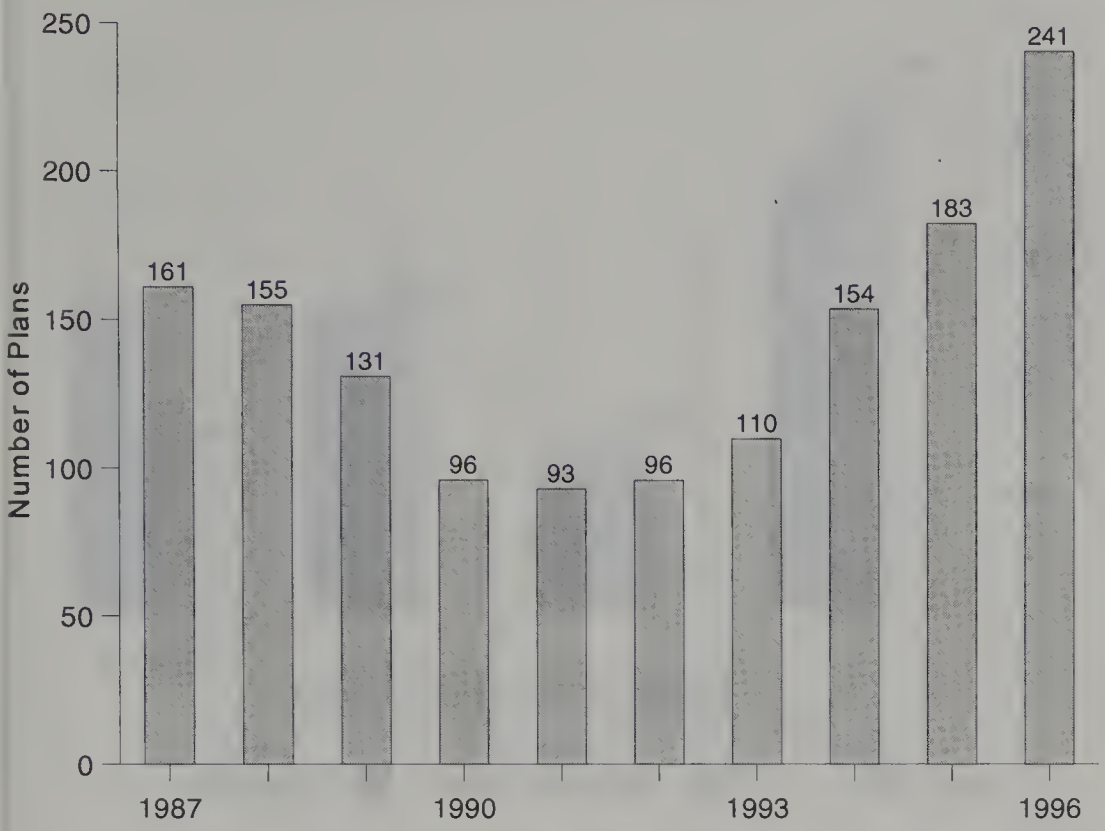
NOTE: Data for workers refers to workers in firms of 200 employees or more
SOURCE: PPRC analysis of data from HCFA and KPMG

Figure 2. Percent of Medicare Beneficiaries Enrolled in Risk Plans, by State, December 1996



SOURCE: PPRC analysis of Medicare Managed Care Contract Report, December 1996.

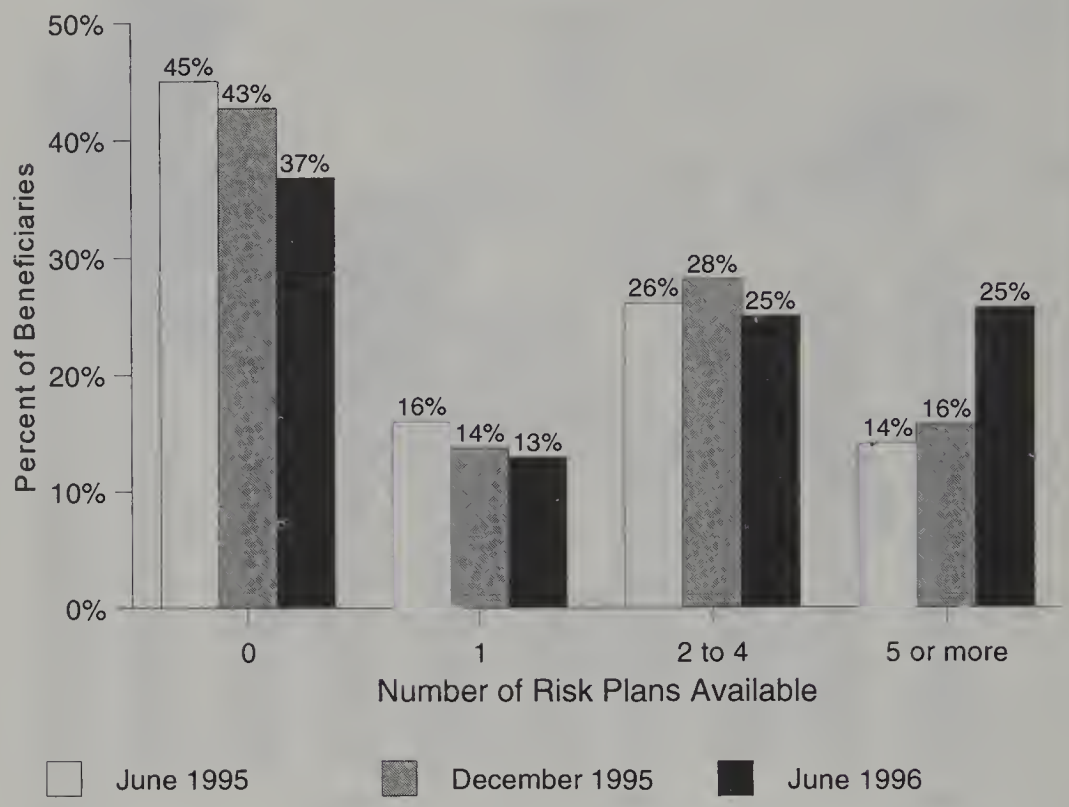
Figure 3. Number of Risk Plans Participating in Medicare, 1987-1996



TE: All data are for December.

URCE: Health Care Financing Review, 1996 Statistical Supplement; Medicare Managed Care Contract Report, December 1996.

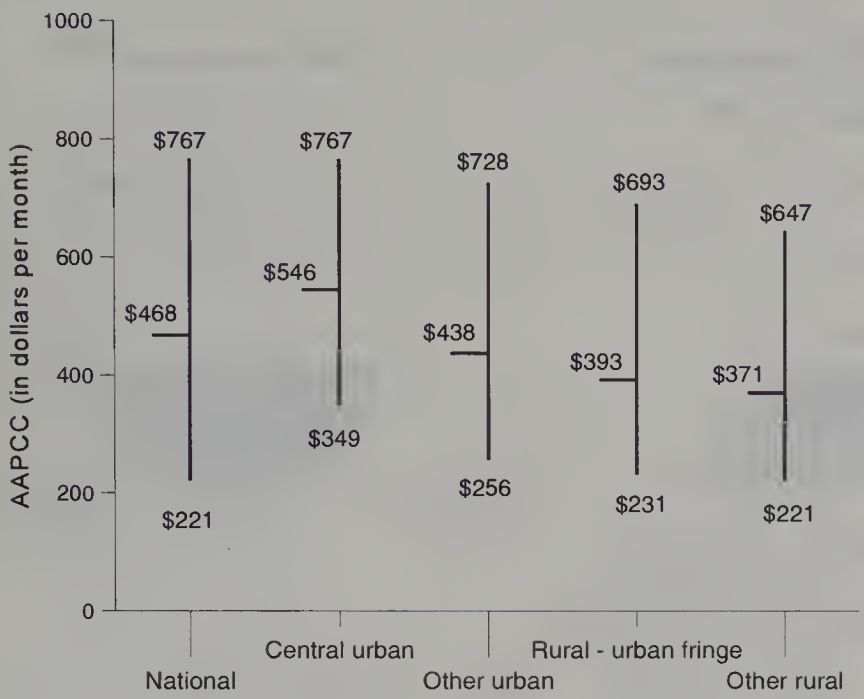
Figure 4. Distribution of Medicare Beneficiaries, by Number of Risk Plans Available in Their Area, 1995-1996



NOTE: Area is defined as the zip codes in a risk plan's service area.
SOURCE: PPRC analysis of HCFA data.

Figure 5. Spread of County AAPCCs by Location, 1997

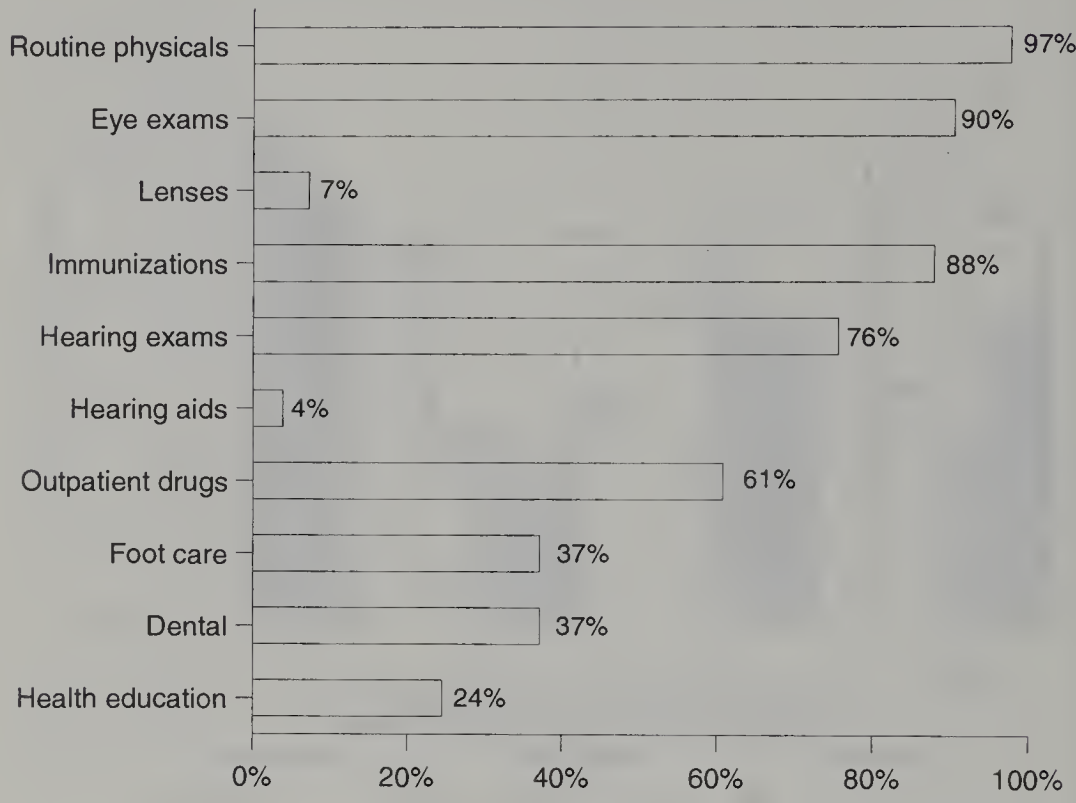
Minimum, Maximum, and Mean weighted by beneficiaries



NOTE: Three AAPCCs are presented for each category: the lowest and highest among the counties and the mean weighted by the number of beneficiaries per county.

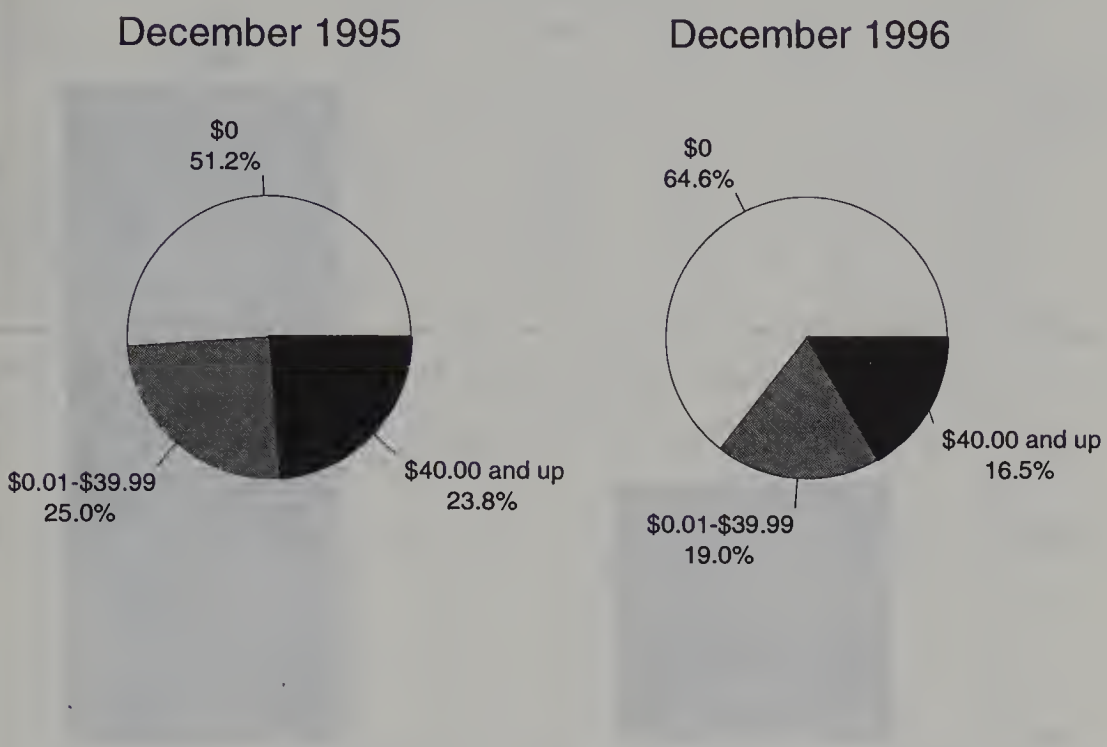
SOURCE: PPRC analysis of HCFA data.

Figure 6. Percentage of Medicare Risk Plans Offering Additional Benefits in Their Basic Option Package, December 1996



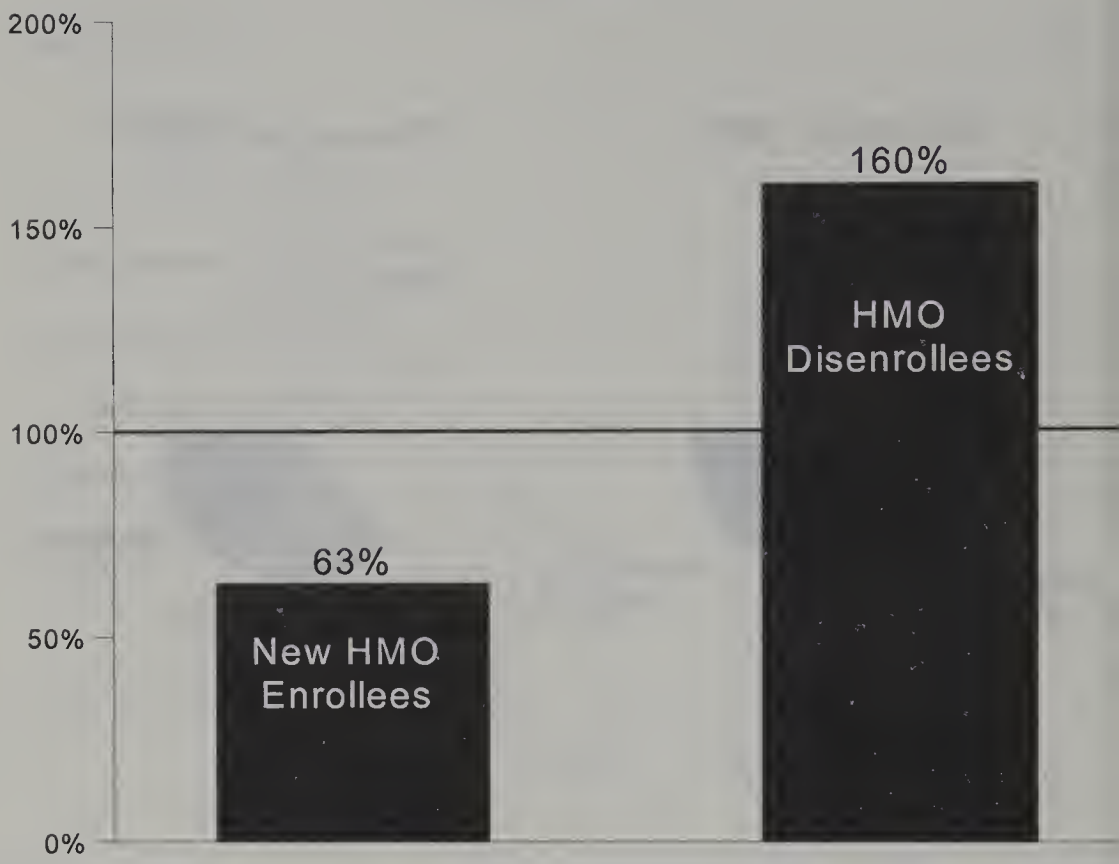
SOURCE: Medicare Managed Care Contract Report, December 1996.

Figure 7. Distribution of Medicare Risk Plans by Premiums Charged, 1995-1996



SOURCE: Medicare Managed Care Contract Reports.

Figure 8. Costs as Percentage of Average Medicare Spending per Beneficiary



SOURCE: PPRC analysis of 1989-1994 Medicare claims and denominator files, 5 percent sample of beneficiaries.

Figure 9. Length of HMO Enrollment for Medicare Enrollees in Five Large Risk Contracts, June 1994

ength of nrollment n Years	PERCENT OF ALL ENROLLEES Plan A	Plan B	Plan C	Plan D	Plan E	Total for Top 5
nder 1	11%	22%	14%	7%	18%	15%
- 2 years	12%	23%	11%	6%	17%	14%
- 3 years	8%	13%	11%	5%	11%	10%
- 4 years	6%	8%	12%	5%	10%	8%
- 5 years	5%	6%	10%	6%	7%	7%
or more	59%	28%	41%	71%	38%	47%

OURCE: PPRC Analysis of Medicare 5 Percent Enrollee Data Base (EDB) file.

OTE: Age-ins are individuals who enrolled in the HMO in their first month of Medicare eligibility. Age-ins were placed in the "6 or more" category.

The CHAIRMAN. Dr. Thorpe.

STATEMENT OF KENNETH THORPE, PH.D., PROFESSOR, DEPARTMENT OF HEALTH SYSTEMS MANAGEMENT; DIRECTOR, INSTITUTE FOR HEALTH SERVICES RESEARCH; TULANE UNIVERSITY SCHOOL OF PUBLIC HEALTH AND TROPICAL MEDICINE, NEW ORLEANS, LA

Mr. THORPE. Thank you, Mr. Chairman, Senator Breaux, Senator Hagel. I am pleased to be with you here today and enjoy the opportunity to present some thoughts about some longer term reforms to the Medicare program. You have heard an excellent discussion of ongoing problems and some potential solutions to the existing Medicare program. I am here to outline some potential structural reforms to the Medicare program for the next century. These structural reforms would at least allow the Medicare program to sustain some of the momentum that you and the president have already developed in the existing or soon to be budget agreement, which allows the Medicare program essentially to grow at a similar rate to what we see in the private sector. So these are reforms really that would follow on top of what has already been agreed upon.

My remarks are going to focus on three areas. First, what are some transitional steps that could be taken now to move toward a longer-term structural reform of the program? Second, I am going to talk a little bit about some of the key elements of a competitive bidding process where Medicare would move much closer to a program like the Federal Employees Health Benefit Program. Third, just to talk about some options with respect to vouchers and defined contributions.

Let me start with the transitional steps. Those are going to focus on three areas. The first thing that would be a helpful transitional step would be to expand the number and variety of health plans that are currently available to Medicare beneficiaries. Under current law, beneficiaries generally have a choice of only the traditional program and HMOs. That is quite different from what we see in the private sector where employees have choices of HMOs as well as more hybrid models called point of service models. Indeed, the transition the private sector took toward managed care was not through the HMO route per se, but really by encouraging the growth of some of these hybrid models such as point of service plans.

Indeed, about 41 percent of private sector employees and their families are enrolled in point of service plans. It is the most popular managed care choice. A second transitional step would be to redefine market areas that Medicare uses to pay health plans to match managed care payments with plan service areas. These would be larger than a county-based reimbursement measure that is currently used. Indeed, again, in the private sector, health plans and employers and health plans in the Federal Employees Health Benefit Program negotiate capitated rates on broader market areas. Those broader market areas will tend to smooth out some of the fluctuations that Ms. Foote has pointed out in her chart. Health plans are used to dealing with negotiations on a plan service area as opposed to a county area, and I think that that may be a useful thing to look at.

A third transitional step would be to continue to explore risk adjustment demonstrations. I think one of the real keys to moving Medicare towards a more competitive model is its ability to more accurately adjust for risk. A risk adjustment demonstration might be an avenue that could advance some of the thought within HCFA and Congress on how to improve on the current AAPCC method.

I think with these transitions in place, Congress could explore several competitive approaches to restructure the program. Let me start quickly with competitive bidding. I am just going to outline some of the key features of the competitive bidding process and highlight some of the key policy choices that would be imbedded within such a process.

First, a process that would rely on competitive bidding would have HCFA or the Department of Health and Human Services solicit bids by health plans within defined market areas. These health plans would include HMOs or other forms of managed care plans and potentially plans that would also offer the traditional Medicare package within a fee-for-service setting. That is similar to the way the FEHBP currently provides fee-for-service benefits. Alternatively, fee-for-service could retain its traditional role as it is administered by HCFA. This would allow competition between managed care plans and the fee-for-service plans within market areas. One of the issues will be the benefit package that is part of the bidding process, is it simply the existing Medicare benefits or a broader set of benefits.

Second would be an annual open enrollment period, which the department would have a coordinated enrollment period, with rules surrounding plan marketing, where Medicare beneficiaries would be able to select among the health plans that are offered in their area.

A third piece of the competitive bidding model and perhaps one of the most controversial and important parts of it would be determining how Medicare sets its contribution rate. We have had a lot of discussion here about the AAPCC. Within a competitive bidding approach, Medicare faces several alternative choices to determine what it pays health plans. One approach would be to set its payment to health plans on the lowest bid in the market area. Another approach would be the second lowest bid or perhaps even at the median or some percentile of the bids.

Alternatively, Medicare could base its payment rates on some external index or the year to year amount that they pay is indexed to the growth in private health insurance or by something else such as the consumer price index. Mr. Chairman, I will go very quickly.

The CHAIRMAN. Please proceed.

Mr. THORPE. The fourth part of this would be what do Medicare beneficiaries pay? In general, what they would pay would be the difference between the Medicare payments, and I just outlined several different ways that Medicare could structure its contribution, and the plan that they select. So the Medicare beneficiary would be responsible for the difference.

The next part of this, the sixth piece, would be beneficiary protections, and this is really perhaps one of the most central pieces of moving to a competitively bid program. Under current law, Med-

icare beneficiaries do have a number of protections and information provided to them, information on benefits, premiums, cost-sharing, lock-in requirements, protection against balanced billing as well as grievance mechanisms. The transition to a more competitively based model, I think, would have to beef up many of these consumer protections to make sure that the system was working on price efficiency and quality and not on selection so that has to be a central part to this process.

I outlined briefly some options with respect to providing vouchers. They rely on many of the same structural changes in the Medicare program I just highlighted. They are part of my written testimony, and in the sake of time, I will not focus extensively on those other than to simply note that they require many of the same types of structural changes in the program.

Now let me just quickly in summary say that this is an approach that I think Congress could think about with respect to Medicare policy perhaps for the next century. It is a fundamental change in the way that Medicare would be structured, the way that Medicare beneficiaries select plans, and the way that the government interacts with the Medicare program. Nonetheless, it could be a useful tool to make sure that the future growth in Medicare spending really moves in alignment with what we are expecting to see in the private sector. Thank you for the opportunity to be here and be happy to answer any questions you may have.

[The prepared statement of Mr. Thorpe follows:]

STATEMENT OF
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Introduction and Background: The Context for Structural Changes in Medicare's Managed Care Payment Policies

Mr. Chairman, and members of the Senate Special Committee on Aging, I am pleased to be here to outline several new approaches for increasing the choice of health plans in the Medicare program. Under current law, Medicare beneficiaries may choose the traditional fee-for-service program or (where available) a health maintenance organization (HMO). Over the past five years, Medicare beneficiaries have, with increased frequency, selected the HMO option. As of May 1997, nearly 5.3 million Medicare beneficiaries (14.3 percent of all Medicare beneficiaries) are enrolled in a prepaid plan. Of this total, 4.6 million are enrolled in one of 280 Medicare risk contracting plans.

Enrollment in HMOs has increased sharply over the past five years; enrollment in Medicare risk contracts have grown by 3.2 million enrollees between December 1991 and May 1997. Six percent of the enrollment growth occurred in 9 states that had no Medicare risk enrollees in 1991 (New Jersey, Louisiana accounting for most of the growth). Under current law, the Congressional Budget Office projects that approximately 35 percent of Medicare beneficiaries will enroll in prepaid plans by the year 2007.

Though participation in Medicare risk-contracts is growing rapidly, the existing payment methodology likely has contributed to the relatively (i.e. compared to the private sector) slow growth in managed care as well as the limited (if any) savings traced to increased managed care enrollment. Under current law, additional enrollment in managed care plans will not generate savings similar to that observed in the private sector. Factors contributing to this dilemma include:

- The likelihood that Medicare currently overpays health plans more than they otherwise would pay under fee-for-service Medicare. The most prominent study of this issue (by Mathematica Policy Research) concluded that Medicare pays 5.7 percent more to HMOs than would have been spent on the same enrollees in fee-for-service Medicare. However, other studies have reached different conclusions.

- Linking risk plan payments to estimates of what the program would have paid if the beneficiary remained in the fee-for-service sector. Thus, per capita growth among beneficiaries enrolled in managed care and fee-for-service plans rise at similar rates;

- A limited variety of managed care plans are currently available to beneficiaries (though both the Congress and Administration have advanced proposals to increase the range of plans);

- Under current law, cost savings generated by managed care plans go to the plans themselves and beneficiaries and not the federal government. Medicare currently returns the savings generated by managed care plans in delivering Medicare services back to the enrollee in the form of additional benefits (for example, 97 percent of plans provide routine physicals, 70 percent provide outpatient drug benefits). As a result, program savings are limited to the 5 percent reduction made to the per capita fee-for-service expenditures (assuming no adverse selection);

- The market area used to calculate Medicare risk contract payments is too small (the county), is subject to wide yearly variation, is likely too low in rural areas and too high in several urban areas. This discourages growth in managed care plans in certain markets, and concentrates plan growth in profitable markets. Both trends limit potential savings to the Medicare program from additional managed care enrollment.

Policy Options for Restructuring Medicare

The issues raised above suggest that changes in the current approach for paying managed care plans could generate savings without undermining the additional benefits currently provided by HMOs to Medicare beneficiaries. At issue is how beneficiaries would be protected under a restructured system (both in terms of benefits they receive and what they pay for them) and how Medicare could share in the savings. An important element of the future restructuring of Medicare is whether current policy initiatives developed by the Administration provide the foundation for the movement toward more competitive approaches. The policy objectives of restructuring Medicare are to provide broader choices of health plan options for beneficiaries, continuous improvement in the quality of care, and savings for the Medicare program. With respect to savings, one reasonable policy goal is to align the per enrollee growth in Medicare with the private sector. The current budget agreement between the President and the Congress, which would generate $115 Billion in Medicare savings over the next five years, would reduce the per enrollee growth in Medicare from 7.5 percent to 4.4 percent between federal fiscal year 1998 and 2002 (see Table 1). This compares favorably to the 4.7 percent projected by the CBO for private health insurance (per insured) over the same time period. The options presented below are designed to sustain this re-alignment between per enrollee growth in private health insurance and the Medicare program.

Alternative approaches for expanding the choice of health plans, as well as relying on managed care to generate program savings, require significant changes in current policy. The following

sections outline briefly some alternative approaches that would address these issues. I develop these options in three stages; the first stage discusses the necessary foundations for longer term restructuring that should accompany any of the competitive reform or defined contribution options. The second stage discusses transitional changes in the program anticipating a new approach, while the final section discusses briefly the key elements of a competitive bidding process and a defined contribution/voucher approach.

The Foundations for Longer Term Reform

The reforms outlined below will depend on the ability of Medicare beneficiaries to have adequate and timely information on health plan choices, a broader variety of choices, federal standards concerning plan behavior, and beneficiary protections. The Administration, through HCFA, appears active on all fronts in laying this groundwork, though additional work will be required to set the stage for any competitive bidding process. Information on plan choices available to Medicare beneficiaries must be available each year (one useful model is the information provided by the Office of Personnel Management at OPM or the Checkbook Guide to Health Plans that provides a wide variety of information to federal employees about plan choices). National marketing guidelines should be established. Efforts to measure the quality of care provided through fee-for-service Medicare and by health plans is critical. This would include monitoring plan disenrollment patterns and the development of outcome measures. These outcome measures of performance should be provided to beneficiaries to assist in their plan selection decisions. Developing outcome measures is high on the agenda of both private and public sector purchasers of care. Most importantly, beneficiary protection against balance billing should accompany any future changes in the system. My reading of various testimony provided by HCFA through its Administrator indicate that the Administration is active in each of these areas. Moreover, I commend you, Senator Grassley, and the committee members for your important work in the area of plan information provided to Medicare beneficiaries. These efforts should continue and hopefully accelerate.

Transitional Steps

In addition to the foundation efforts outlined above, several transitional steps would be required to facilitate competitive plan bidding.

- Expanding the number and variety of health plans available to Medicare beneficiaries.

  Under current law, HMOs are generally the only choice Medicare beneficiaries seeking alternatives to "traditional" Medicare currently have. In contrast, managed care arrangements in the private sector include both HMOs as well as several "hybrid" models. These models allow consumers the flexibility to decide whether they want to receive care in a "fee-for-service" environment or in an HMO style environment each time they seek medical care. Under this option, enrollees are not locked into the HMO , and instead have the flexibility of choosing either network as well as out of network providers. These

point-of-service (POS) managed care arrangements are among the most popular forms of managed care in the private sector (see Table 2).

During the past two years, the Health Care Financing Administration has sought to increase the variety of managed care choices available to Medicare beneficiaries. Medicare Choices, for instance, is a demonstration project that seeks to expand the variety of managed care choices. The current project includes provider sponsored networks, and a preferred provider organization among other hybrid plan. These demonstrations should be carefully evaluated, and where successful expanded. A substantial volume of experience with such plans is also available from the private sector.

- Redefine Market Areas and Match Managed Care Payments with Plan Service Areas

Managed care plans in the private sector often negotiate capitated arrangements with employers within a plan service area, the area that includes the network hospitals and providers. Capitation rates are based on expected costs within the network area. With few exceptions, these plan service areas are considerably broader than a single county. While current proposals to establish minimum payment rates in low AAPCC counties represents an important first step in this process, matching payments with plan service areas could accelerate the diffusion of managed care in low penetration areas.

- Risk Adjustment Demonstrations

In addition to expanding the variety of health plans contracted with through the Medicare program, improvements in the current Average Adjusted Per Capita Cost (AAPCC) method seem warranted. Several promising approaches improving on the current AAPCC method are in development, including Ambulatory Care Groups and Hierarchical Co-existing Conditions (HCC)[1]. Blended approaches mixing fee-for-service and capitation payments may also prove promising. Improving on the AAPCC is critical if Medicare is to move aggressively toward a more market based approach.

With these transitory steps in place, Congress could explore several competitive approaches to restructuring the Medicare program. These approaches are derived largely from on-going experiences of the private sector. Where appropriate, I compare the recent experience of the private sector and speculate on their relevance for a restructured Medicare program. These strategies are presented in the following sections.

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[1]Ellis, R, et al. "Diagnosis-Based Risk Adjustment for Medicare Capitation Payments," Health Care Financing Review 17(3) Spring 1996: 101-128; Weiner J. et al. "Risk-Adjusted Medicare Capitation Rates Using Ambulatory and Inpatient Diagnoses, Health Care Financing Review, 17(3) Spring 1996.

I. Competitive Bidding

A competitive bidding strategy would involve (at least) the following several steps:

1. Submission of Bids by Health Plans.

The HCFA would solicit bids from health plans within (redefined) market areas. These market areas would be defined in advance by HCFA or defined by the plan as part of their bid. In the latter case, however, some standards concerning market areas should be established in advance (i.e. minimum market area size). Health plans would include HMOs, other forms of managed care described earlier (i.e. POS plans) as well as bids to provide fee-for-service Medicare benefits (perhaps similar to the Blue Cross provision of fee-for-service under the Federal Employees Health Benefit Program (FEHBP))[2]. Alternatively, fee-for-service Medicare could retain its existing structure, administered by HCFA. This bidding process would allow competition among all forms of health plans, HMO, POS as well as fee-for-service plans.

Several options exist concerning the nature of the bidding process. Of particular importance is the benefit package included in the bid. Under one approach, health plans would bid on the basic set of Medicare benefits, and provide a separate supplemental premium to cover additional benefits. Another approach would allow the plans to submit bids on both their premiums as well as the scope of benefits they provide. This would be similar to existing Medicare contracting policy with respect to HMOs. The FEHBP also structures their negotiations with plans in a similar manner (i.e. both premiums and the scope of benefits provided differ across managed care plans).

2. Annual Open Enrollment.

Each year, Medicare beneficiaries would choose among the several options in their service area during an open enrollment period. Several issues exist concerning the enrollment period, including the length of time, rules surrounding plan marketing, and issues concerning plan disenrollment. An annual open season would depart significantly from current policy. Under current law, beneficiaries may enroll or disenroll from HMOs monthly. As a result, it may be prudent to transition to an annual enrollment option (perhaps starting with a biennial enrollment option). One approach is to structure the enrollment process using the FEHBP model. Each year, federal employees may select among several plans during a month long open season period (this year open season ran from November 11 through December 9, with 388 health plans participating in the program).

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[2]Whether fee-for-service administered by a health plan could compete with the range of managed care plans under this option is highly uncertain. The viability of this approach would depend largely on the ability of HCFA to improve on their current risk adjustment methodology.

3. Establishing Medicare Payments to Health Plans.

Perhaps the most controversial and important aspect of a competitive bidding plan is the process used by Medicare to define its payments to health plans. Within the broad structure of a competitive bidding process, Medicare faces several choices in structuring its contribution. A common element across all choices, however, is the de-linking of Medicare's payments to managed care plans from local fee-for-service costs. Instead, Medicare's payments to health plans would be established through the competitive bidding process. In determining its contribution, Medicare could simply accept the bids, and

- Base its payment on the lowest cost plan in the market;
- Base its payment on the second lowest cost plan (or some variation of the low cost plan, say 5 percent above the low cost bid), or
- Base payment on a percentile of the premium bids (e.g. 50th percentile)

Alternatively, rather than simply accepting bids from health plans, Medicare could bargain multilaterally with health plans over prices and scope of service. With this approach, health plans would make their bids with the HCFA presenting counterproposals (if they desire) sequentially. The bidding process would stop when either the health plan accepted a counterproposal or HCFA accepted the health plan bid.

A third approach would tie both the level and growth in premiums quoted by health plans to those offered in the commercial market. With this decision rule, HCFA could then establish its contribution using one of the decision rules noted above. This "most favored customer" approach to plan bidding would ensure that the growth in Medicare payments parallels the experience in the private sector. This strategy is in the same spirit as the current negotiations between the FEHBP (through the Office of Personnel Management) and each of the local managed care plans.

A final approach would link the growth in Medicare's contribution to a health plan to an external index. Examples would include the projected growth in private health insurance spending per enrollee, or a multiple of the consumer price index or gross domestic product.

4. Establishing Payments for Medicare Beneficiaries

In general, beneficiaries would pay the difference between the premium charged by their health plan of choice, and Medicare's contribution.

5. Plan Rating.

Plan bids would be community rated, and then risk adjusted based on actual enrollment. HCFA

could use its existing AAPCC methodology, though a next generation risk adjuster is desirable and perhaps critical to assuring the viability of this strategy.

6. Beneficiary Protections.

Under current law, Medicare beneficiaries have a number of protections, including information on benefits, premiums, cost-sharing, lock-in requirements, protection against balanced billing as well as grievance mechanisms. Improvements to these protections will be required. These include methods for distributing information to Medicare beneficiaries, as well as guidelines concerning clear, consistent and accurate information relating to plan marketing during the open enrollment season.

II. Defined Contribution And Vouchers

Another option is to change the Medicare program from a defined benefit program to a defined contribution. This strategy would require many of the market restructuring approaches highlighted above. Medicare could provide a "voucher" to each beneficiary based on the actuarial value of the benefit package. Beneficiaries would choose to remain in the traditional Medicare program, or receive the actuarially based voucher amount. The voucher could be used to select among health plans offered through the program. Two of the most important design issues facing a voucher program are establishing the dollar value of the voucher as well as the yearly dollar increment provided Medicare beneficiaries. A second issue concerns Medicare's organization of the plan bidding process. These could operate in tandem, or separately. Vouchers provided to Medicare beneficiaries could be based on;

- The projected (per enrollee) growth in private health insurance established by the Congressional Budget Office;

- Some other externally generated index (such as the consumer price index, or gross domestic product);

- The bids submitted by health plans in each plan service area (i.e. the lowest bid, average bid);

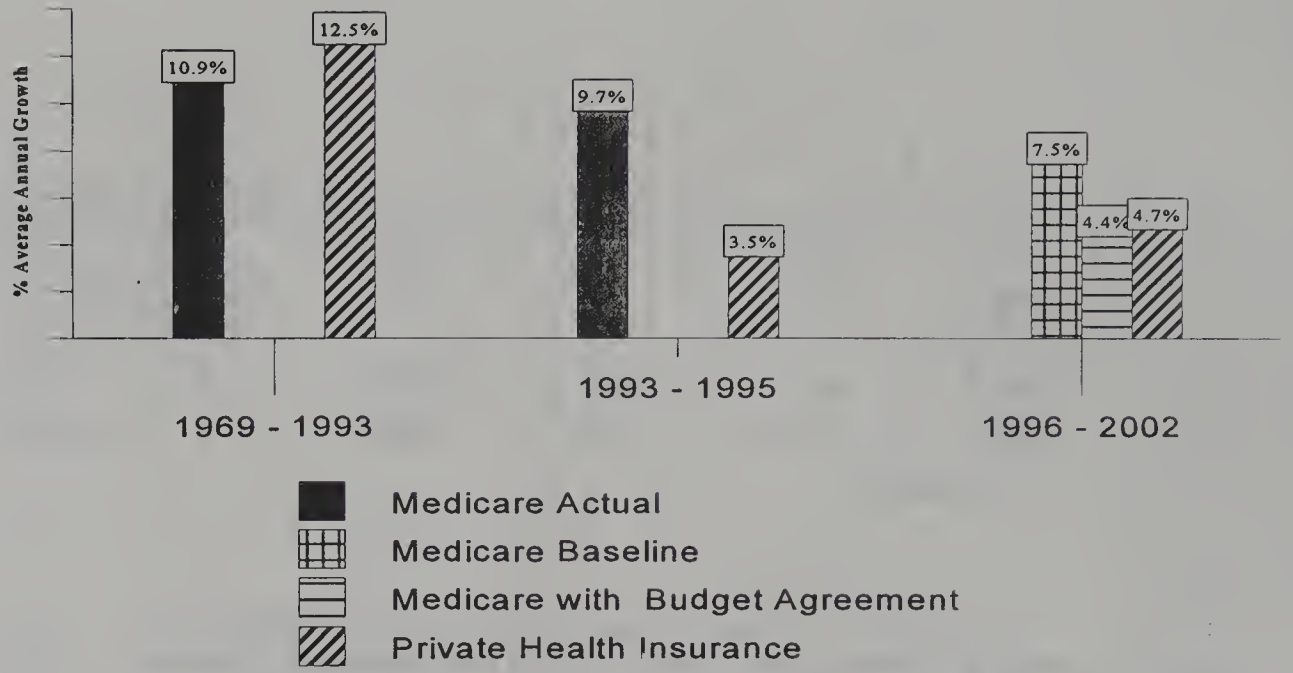
However, simply providing beneficiaries vouchers will not bring additional efficiencies into the Medicare program. Reforms of how health plans are paid would have to accompany any voucher plan. Indeed, providing a defined contribution in the form of a voucher without changing Medicare's current methods of paying health plans could result in beneficiaries paying substantial increases in out-of-pocket spending on health insurance premiums. Thus, Medicare would also have to organize the supply side of the market to guarantee that the vouchers received by beneficiaries would have some relationship to the premiums charged by health plans in their area. In this regard, the program could use any one of the competitive bidding options highlighted earlier, a single bidding process, the double bidding approach (where HCFA counters initial

bids), or an indexed based approach.

Conclusions

The proposals outlined above could allow the growth in Medicare to parallel the experience in the private sector, provide a broader range of plan choice for beneficiaries, and improve the quality of care provided Medicare beneficiaries. These approaches could also sustain Medicare's expected per enrollee growth resulting from the recent budget agreement at or slightly below the expected growth in private health insurance past the year 2002. However, to achieve these goals, the federal government must assume an active role in developing and monitoring the marketing of plans, providing information to beneficiaries, measuring and reporting on the quality of health care and pursue an aggressive approach for protecting Medicare beneficiaries.

Table 1: Historic and Projected Growth In Per Capita Private Insurance and Medicare Spending



Source: HCFA and CBO Projections

Table 2: Percent Distribution of Private Sector Enrollment in Managed Care and Conventional Fee for Service, 1992 - 1996

	YEAR				
Plan Type	**1992**	**1993**	**1994**	**1995**	**1996**
HMO	22%	26%	25%	29%	33%
Preferred Provider Plus Point-of-Service	33%	32%	40%	40%	41%
Conventional	45%	42%	35%	31%	26%

Source: KMPG Surveys of Employer Sponsored Health Benefits

The CHAIRMAN. Thank you very much. This is outstanding testimony, and I know you folks have been in the middle of this issue for a long time, and so we are kind of starting over again this time, and hopefully we get all the way this time. I will start with you, Ms. Foote, and that is in regard to the administration's effort to include in their provisions for AAPCC review hold harmless provisions for HMOs serving high cost areas. Could you explain the effect such a provision would have and tell us whether it is consistent with the goals of increasing equity and choice for seniors in all the areas of the country?

Ms. FOOTE. Well, I find the Administration plan rather confusing because there are so many different factors that are all intersecting. It is hard to really parse through it and find out what exactly or how they all relate, but I think as a goal, if our goal is to over time gradually bring the payment rates across the country into some norm that reflects the costs of care in those marketplaces, you cannot hold the top high over time without reducing the speed in which you get to equity. The benefit of working off of the future growth is that you can reduce the disruption by redistributing the money off of the future growth rather than resting out dollars that are currently in the system but ultimately just like we did with the DRG's, you know, when you move toward equity some people who are, you know, $300 or $400 per person per month above the average are going to have to slow down or come down.

The CHAIRMAN. Yes. Do either one of you have a view on the hold harmless provision before I go on to my next question? OK. Also, you mentioned instituting a payment floor and a rate that blends the local and the national rate. Which is more important and do different areas benefit with one over the over?

Ms. FOOTE. Well, there is really two different kinds of markets that are below the average. The middle markets, which are many of the smaller urban areas, Omaha, Des Moines, efficient markets like Portland and Minneapolis and Seattle, Salt Lake City, those areas really will benefit more directly from the blend. They are over the payment minimum rates, but they are below average and falling further and further behind relative to the average. Senator Wyden had a gap widens chart that walked out with him, but it shows that over time this sick payment system is making things worse. So for those middle markets, which Des Moines is one, you really need to use the blend to bring them closer to the average.

For the rural areas, where the underservice and the under utilization is so severe, the only way that you can get immediate results, as Mr. Brenton was talking about, is to institute a minimum payment that no area can fall below, and that minimum payment in various of the bills has been talked about at 80 percent or 85 percent of the national average. That cuts off the tail and elevates most of rural America into contention. Now those amounts will not get them free drugs, will not get them unlimited eyeglasses and all those other things, but it will get them a choice of a health plan if Mr. Brenton's projections are correct.

The CHAIRMAN. On the issue of graduate medical education, that is paid indirectly now through the HMO. There is a lot of feeling here in Congress that might be more efficient to do it directly with an appropriation or some sort of a trust fund for medical education.

What difference does it make whether the graduate medical education is carved out or not in terms of creating choices in Medicare for beneficiaries all over the country?

Ms. FOOTE. Well, the coalition is concerned that reform of graduate medical education occur and we know it is an important fairness and equity issue. We are concerned that the techniques by which graduate medical education is addressed do not contradict the goal of getting to equity. Not all the high payment areas are high because they have graduate medical education in them. Some of them are high because they have utilization patterns that are, you know, four to five times higher per capita than the norm. So I think in addressing the graduate medical education issues, you really have to weigh it in relationship to the goal of equity and make sure that your solutions in that area do not set back the goals of equity in the long run.

The CHAIRMAN. So then the graduate medical education would be carved out before we would do the blending?

Ms. FOOTE. I think it is probably more effective to address the graduate medical education issue after you have begun to address the inequity, particularly in the lower areas.

The CHAIRMAN. I will call on Senator Breaux.

Senator BREAUX. Thank you very much, Mr. Chairman. Thank the panel. Susan, how does it feel to sit on that side of the table?

Ms. FOOTE. Oh, it is terrific. I like it a lot.

Senator BREAUX. Well, we are glad you are back.

Ms. FOOTE. Thank you for the opportunity.

Senator BREAUX. Glad you are back. I tell you, the more I learn about all of this the less I know about all of this. I mean it is so incredibly confusing, and the only principles that are true and clear are that seniors generally love Medicare, and the second principle is that unless we do something to fix it, it runs out of money in 4 years. But also true is that most people do not want their services cut nor their costs increased. I mean we got all kinds of immovable objects that are getting ready to collide right here, and there is going to be a huge explosion, and I am not really sure what the ultimate long-term solution is. I do know that whatever those ultimate solutions are, none of them are without risk, political risk and risk in general.

Dr. Colby, I guess it was your statement, which I found incredible. On page 11, you say lack of risk adjustment translates into higher costs to Medicare. Your commission estimates that annual excess payments to health plans total $2 billion.

Mr. COLBY. It is $2 billion per year and will grow as managed care becomes a greater part of the program unless we fix the payment mechanism.

Senator BREAUX. Why do you say that there are excess payments?

Mr. COLBY. We say that is excess payments because HMOs are serving healthier beneficiaries and we are basing the payment on the fee-for-service beneficiaries who are sicker.

Senator BREAUX. So we are really paying them $2 billion more than what you would expect the average cost to be for those patients?

Mr. COLBY. Yes.

Senator BREAUX. We wonder why we have a problem.

Mr. COLBY. I believe Bill Scanlon said that GAO had an estimate of a billion dollars for California alone, which is 40 percent of the managed care program. Thus, we are in the same ballpark.

Senator BREAUX. What are your thoughts about a payment floor?

Mr. COLBY. A payment floor?

Senator BREAUX. It has been suggested by the previous panel of $425 minimum payment floor per beneficiary.

Mr. COLBY. The Commission has never taken a stand on exactly how to decouple the managed care payments from the fee-for-service payments so we do not have a recommendation on what the level of the floor should be. One way of decoupling payments is with a floor, a ceiling, and risk adjustment.

Senator BREAUX. But I mean as long as managed care payments are coupled with fee-for-service, there would be other problems, right?

Mr. COLBY. If the fee-for-service payments are too out of line with the managed care payments, we are afraid you might tilt the system towards one delivery system and, therefore, not have real choice available to Medicare beneficiaries. You want to make sure that they are not too far out of line with each other.

Senator BREAUX. We have a Finance Committee hearing Wednesday, and we are going to be talking about exploring an idea that I am going to offer which is to make available to Medicare beneficiaries the Federal Employees Health Benefit Plan, which is based on competition in the marketplace both on prices as well as on benefits that are offered. Do you have any comments on how that would affect or potentially affect the current payment system under Medicare if that were available?

Mr. COLBY. I think you isolated the difference in the ways we were talking about the solutions. We have several solutions which are administered price solutions. One is to fix the AAPCC. Another is to use floors, ceilings, and blending. Then we have several competitive solutions which Ken talked about. Those solutions include competitive bidding and a defined contribution system. Ken outlined very nicely the issues you have to cover when you look at defined contribution. That is what the contribution is going to be and how are you going to set it over time? What are the benefits going to be? Are they going to vary from plan to plan or are you going to have a core set of benefits? Finally, how are you going to set up the competition?

Senator BREAUX. Ken, can you comment? I know you are going to be with us on Wednesday before the Finance Committee. Can you give us some additional thoughts on this?

Mr. THORPE. Well, I think that the floor is probably a nice transition way to encourage the movement of managed care plans into areas that have not traditionally being served by them. I think, though, that a longer term solution to broadening choice really is going to have to focus on decoupling payment rates of health plans from the existing fee-for-service market. Having said that, that then leaves you, I think, in a situation of either structuring it through a bidding process where HCFA negotiates with health plans based on their bids or through some other means. So I really

think that in order to have the plans diffuse, you do need to take some of the steps I talked about, broaden the market areas.

I think even with the payment floors, you will see some of the contiguous counties still varying widely, which allows managed care plans to selectively go into adjacent counties or not, based on the AAPCC. So having a plan service area base definition to structure bids I think is as important as moving toward a different way of determining how Medicare pays the health plans.

Ms. FOOTE. The challenge—

Senator BREAUX. Susan, I know you are recommending the blending formula as well as the floor. Can you tell me in English how the blending formula would work?

Ms. FOOTE. Well, I tried to write it in English in the testimony because it is hard to describe, but the intention is simply if you keep your eye on an average and say that is where we want everyone to end up around an average point, how do we get there in the most sort of smooth transition? The way the blending formula works is that you take the average and then you take your local payment rate and you blend them together. The low——

Senator BREAUX. Gradually. You could not do it all at once.

Ms. FOOTE. Yes. You can move as fast as you want or you can do it over a 3-year period, a 5-year period, but the point is that the lower payment areas that are below average get blended toward the norm by blending a portion of the average with the low, mix it together, and you get something higher than the low, closer to the average. The same is true for the high ones.

Senator BREAUX. But it is still based on fee-for-service charges in the area?

Ms. FOOTE. No, you can do it prospectively. You can cut that link and you can say, OK, we are struck with unlevel playing field we currently have, but for the future we are going to look to establishing a rate that is more consistent and so you do it prospectively. You have to break that link or you are always stuck with these utilization patterns where the rural areas are going to just drag behind because they simply do not have enough utilization to sustain the number.

Senator BREAUX. I want to thank you and your association. I mean the material I know is always in existence, but collecting it and showing it and displaying it in the manner in which you all have done is a real big help for us. I appreciate that. Thank you.

The CHAIRMAN. Thank you. Senator Hagel.

Senator HAGEL. Mr. Chairman, thank you. Based on the testimony the last 2 hours, Mr. Chairman, I think part of the answer is we impanel the seven panelists, we lock them up, we do not let them out until they have figured this out.

Ms. FOOTE. We are ready.

Senator HAGEL. Somewhere in there with those seven panelists the answer is there, long-term and short-term, and I am very grateful as a member of this panel for what you have said today in helping us sort through this. If I could go to you, Dr. Thorpe. I am intrigued with this voucher thought. Would you expand on that a little bit for me?

Mr. THORPE. Well, one of the ways that a voucher could work would be that Medicare beneficiaries would receive an amount

which would be equal to the actuarial value of the Medicare package. The Medicare program then could structure the market through a competitive bidding process, where again they would solicit bids from health plans within an area. They could then either negotiate with the plans over the bids or simply base their contribution on again some relationship to the bids, the low cost bid, the average bid, and so on. That could determine the voucher amount as well. Then Medicare beneficiaries would choose among the health plans. If they wanted a more expensive plan that perhaps did not have as tight of a lock-in requirement, for example, they would pay a little bit more out of pocket. If they wanted to have a plan that perhaps had a tighter lock-in component, they would pay less.

But it really does have to, I think, include two parts. No. 1, is that HCFA does have to structure the market to solicit bids in a competitive process, and No. 2, individuals would then be given an actuarial amount to select among the plans.

Senator HAGEL. Thereby, you would get the Government removed more and also you would focus more on personal responsibility? The marketplace would have more control, would dictate, and I personally, by the way, have always thought that there should be some role for that in this answer, whatever we all come to. Would you develop a little bit the timing of this, whether it is the voucher system or any other, as to how we can come to the kind of programs and the options that we are going to need to come to?

Mr. THORPE. Well, I think it would take several years to develop. I think sort of the good news is that depending on what finally happens with the agreement that you have reached on Medicare that you will have over the next 5 years the growth in per enrollee costs in Medicare growing at slightly lower than the per-enrollee costs in private health insurance. So really this is something I think looking beyond the year 2002 perhaps you will need some transition steps. You are going to have to broaden choice of health plans in order to make the market competitive. I think it is going to be clear that you are going to need a next generation way of adjusting for risk and it cannot be the AAPCC. That probably is not adequate to do this. There are some promising different avenues out there that we should perhaps look at in a demonstration project.

Those things could take 5 or so years to sort of feel comfortable with the ability to generate broader sets of plans and the ability to really generate a risk adjustment methodology that we feel comfortable with to make sure that the competition is on price and quality, not on risk, and I think that is sort of the major, one of the major issues that one would have to face in this type of an approach.

Senator HAGEL. Thank you. Ms. Foote, would you like to comment?

Ms. FOOTE. I was just going to say that is why these transition payment techniques are so critical. If you tried to impose the FEHBP model and asked a Blue Cross/Blue Shield plan in western Nebraska to offer a Medicare product with all the benefits that are in the Medicare package for the current AAPCC, they would laugh in your face because it is lower in those market areas than what

they charge to 22-year-old Federal employees. They could not possibly do it. So we cannot get there until we get the payment rates into some range where any insurance company or physician group can walk in and say I will take the risk of serving this beneficiary and offering them everything that the Government has entitled them to under the Medicare program. I have got to have an adequate payment rate. So that transition is so essential to getting to the competitive models that are clearly the preferred models in the long run.

Senator HAGEL. Thank you. Dr. Colby.

Mr. COLBY. There are two steps which would be helpful. One is to encourage the competitive bidding demonstration that HCFA has had problems setting up, and the other is, to examine the lessons from the Medicare choices demonstration. From the Medicare choices demonstration, we will know what different types of plans are doing and the success of different types of options. So I think those will be helpful in moving in this direction.

Senator HAGEL. Thank you, Mr. Chairman.

The CHAIRMAN. Yes. Dr. Colby, I would have a couple of questions, and then if my colleagues have a couple, we will finish. You pointed out the wide variation in medical costs across the country. Is it possible that costs are so different because the health of people in different areas are just so different, and if that does not account for the difference, what do you think does?

Mr. COLBY. Well, the difference in health does account for much of the difference because when we adjust the AAPCC for health status, we change considerably counties' AAPCC. That is, we bring down the high AAPCC's and bring up the low. The other underlying factor in this is the difference in practice patterns which I do not think we understand. Physicians in different parts of the country practice medicine in different fashions. In the scientific literature it is known as small area variation. Since we have very little understanding, I would argue for a gradual movement, a blending over time as a policy.

The CHAIRMAN. OK. Did you want to add to that?

Ms. FOOTE. I was going to say that we do know something about it based on John Wennberg's work up at Dartmouth where he has really done an atlas examining these small areas and has concluded that a large factor in determining these variations has to do with the infrastructure, the number of hospitals including sophisticated hospitals and the number of doctors who live and practice in a community. The more people who are there offering services, particularly in a government run fee-for-service, where if you do the service you get paid the fee, if you look at hospital capacity, you can see that a city like Honolulu, which is a very expensive city, has about 2.7 beds per thousand. A city like New Orleans, I think, has double that. It is not a surprise that there is more utilization in those areas.

So those problems are not something that Congress can immediately solve, but the distribution of physicians is a serious problem. They are not very many. There are 66 counties in Texas with no doctors at all. So those kinds of patterns, which are a problem for all of America really are, I think, explanatory. They may not

explain the whole difference in practice patterns, but I think they are pretty compelling data.

The CHAIRMAN. Dr. Colby, my last question deals with the differences in health status of people in different parts of the country. Let us say that Medicare implemented risk adjustments so that payment to plans would accurately reflect the health status of these enrollees. Is it possible for us to know what areas of the country would particularly benefit from that because beneficiaries in those areas tend to be less healthy?

Mr. COLBY. It is possible. The Commission adjusted the AAPCC's based on health status, using the latest technology that HCFA has developed. That is the hierarchical coexisting conditions, which take into account diagnosis. We did this by standard metropolitan areas and rural parts of State. Miami in 1995 had a $616 AAPCC rate and rural Minnesota had a $263 AAPCC rate. That Miami's rate is 2⅓ times rural Minnesota's rate. If your diagnosis adjust it, there is about a 50 percent greater rate in Miami than in rural Minnesota. There is a longer chart with other areas of the country in our annual report.

The CHAIRMAN. Thank you. Senator Breaux, do you have another question?

Senator BREAUX. No, I am fine. Thank you very much. See you Wednesday.

The CHAIRMAN. Well, thank you all very much for your fine testimony, and as Senator Hagel says, there is a lot of information been given by you seven people and we appreciate it very much and it will help us in our arriving at a solution. I adjourn the meeting.

[Whereupon, at 4:03 p.m., the committee was adjourned.]

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